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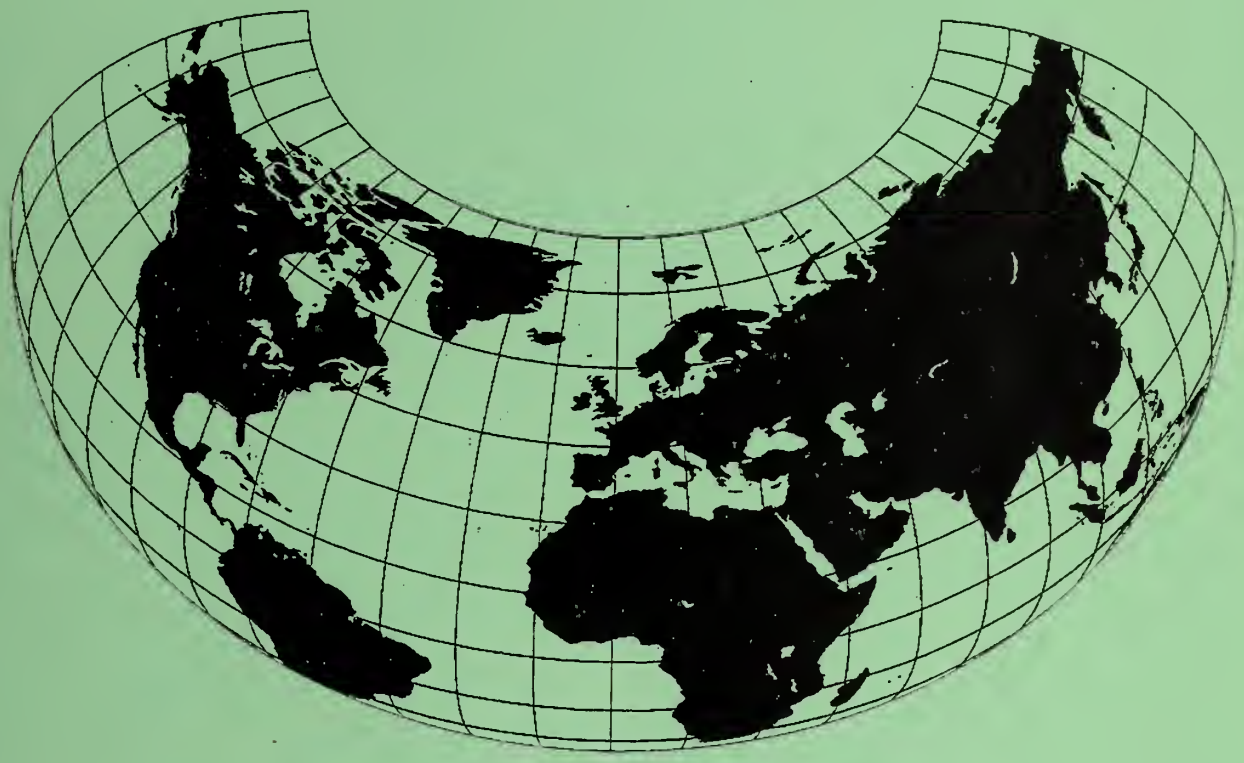
Refugees and Immigrants In Massachusetts 2000

An Overview of Selected Communities



Office of Refugee and Immigrant Health
Bureau of Family and Community Health
Massachusetts Department of Public Health

June 2000

Refugees and Immigrants In Massachusetts 2000

In Massachusetts, whose history has been shaped by immigrants, refugees and immigrants arrive for a number of reasons, come from diverse social, economic and educational backgrounds and adjust to a new country at different paces. Many newcomers are fleeing war, political upheaval or persecution in their home countries. Others are joining families from which they have been separated for years and still others come for work or education. Consequently, their immediate and subsequent health needs vary greatly.

Those coming from countries in upheaval can suffer from a variety of mental health problems and post-traumatic stress syndrome. Often, the loss of family members contributes to difficulties in adjusting. These factors, combined with the stigma associated with mental health in their home countries and being cut off from traditional support networks, may prevent many newcomers from seeking appropriate treatment.

Those from less economically advantaged countries frequently have had less comprehensive care and arrive with basic health needs. Many suffer from inadequate diets, infectious diseases, and lack of proper dental care and immunizations.

On the other hand, there are many similarities of experience for newcomers to Massachusetts. Initially, lack of fluency in English is the first barrier they face in seeking health care. In addition, a lack of understanding of the western health care system can also prevent newcomers from attending to health needs. Help-seeking behavior then becomes one of emergency treatment rather than one of on-going preventive care. Linguistic and cultural isolation, compounded by geographic isolation where there is a lack of appropriate facilities, can complicate health issues.

Further, the stress of adjustment to a new culture, the burden of the past and separation from traditional family and cultural support systems can intensify health problems. For example, intergenerational conflict, domestic violence, gambling and substance abuse are becoming crises in newcomer communities. Again, stigma, isolation and lack of appropriate information and services often prevent newcomers from seeking assistance for these overwhelming problems.

The 1996 federal welfare and immigration reforms have been creating even more barriers for newcomers to access health care and basic nutrition programs. One of the most important barriers was the unclear notion of "public charge." "Public charge" has been used for more than 100 years in U.S. immigration law. The policy has been so confusing, that immigrants have avoided seeking basic health care, school lunches, child care and other needed services because of the fear that it would lead to denial of a green card or deportation. Fortunately, on May 26, 1999, the U.S. government published in the *Federal Register*, a Notice of Proposed Rulemaking that clarifies the circumstances under which a non-citizen can receive public benefits without becoming a public charge." The new regulations, for the first time, define "public charge" and state which benefits a non-citizen may receive without concern for negative immigration consequences. Two other initiatives also happened last year. First, the *Fairness for Legal Immigrants Act of 1999* introduced by Senator Moynihan and Representative Levin, tried to restore eligibility to some people who were in the U.S. before the welfare bill passed, and to others who become disabled after they enter the U.S. Then towards the end of 1999, the *Hunger Relief Act of 1999* introduced by Senator Kennedy and Representative Walsh sought to restore food stamps benefits for immigrants and provide States with flexibility in administering

the food stamp vehicle allowance. Unfortunately, both bills have not passed. Most likely, they will be incorporated into another bill or the budget.

In the Commonwealth of Massachusetts, owing to the dedicated efforts of advocates and an exceptional sense of care in state government's executive and legislative branches, the most destructive impacts of the reforms could be warded off. Refugees and immigrants living in this state and ineligible for federal programs can be provided with safety net benefits. But more vigilance is still needed to assure support and services to the commonwealth's newcomers, especially to the most vulnerable subgroup: the elderly.

Although many hospitals and clinics work closely with newcomer communities and can provide translators and bilingual staff who understand different cultural approaches to health care, there is still a demand for these services. On-going education, awareness, interpreter services, and medical staff trained in cross-cultural health issues are needed to serve appropriately and adequately the newcomer population. It was, therefore, with great joy that the latter learned about the signature by Governor Paul Cellucci of the "Emergency Room Interpreter Bill, H.4917" into law, on April 14, 2000. The law, which will go into effect on July 1, 2001, requires competent interpreter services in the delivery of emergency health care services or acute psychiatric services. Let's hope that this important legislation will pave the way for more comprehensive interpreter services in any health care service setting.

About the demographic data used in this publication

Up until recently, this publication has been using mainly estimates from resettlement and community agencies for demographic data of newcomer communities in Massachusetts. The reasons why census figures were less utilized are that: 1. Censuses are taken only every ten years, and their data becomes outdated when there is an influx of newcomers; 2. Newcomers do not respond adequately to a census because of language barriers and the fear and mistrust they feel of public inquiries. Independent studies have shown that census figures represented substantial undercounts for many newcomer communities. This consideration does not, on the other hand, mean that community estimates are always reliable, as some of them may be overblown. Fully aware of the above mentioned dangers, the Office of Refugee and Immigrant Health has been working with friends within and without the Department of Public Health to improve the demographic figures of this report. Birth data and school enrollment figures have been studied to complement census data and community estimates. Pending the results of this new methodology, and especially of Census 2000, and with a view to providing helpful elements for comparison, this edition offers two sources of demographic data: 1990 census figures, and community estimates.

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Albanians

Albanian Population in Massachusetts:

1990 Census: U.S. / Ancestry	1990 Census: MA / Ancestry	2000 Community Estimate
47,710	7,710	33,000

Country/Regions of Origin:
Albania is located north of Greece on the Adriatic Sea. Clockwise, it is surrounded by Montenegro, the Serbian province of Kosovo (*Kosova* is the Albanian spelling for the region's name), the former Yugoslav Republic of Macedonia, and Greece. Roughly 230 miles long by 90 miles at its widest point, Albania is about the size of Maryland.

Numbering approximately 3,200,000 people, Albania has about the same population as greater Boston. There are, however, as many Albanians living just outside of its borders as there are within it. There are approximately 40,000 Albanians living in Montenegro, almost two million in Kosovo, 100,000 in south Serbia, 600,000 in Macedonia, and 250,000 in northern Greece.

Migration Trends:
Reverend Nicholas Christopher is known to have been the first Albanian to settle in Massachusetts, immigrating in 1886. Six churches were built through the turn of the Century to 1919, firmly establishing an Albanian community in Massachusetts. The European economic depression of the 1930's caused emigration from Albania, as did the Balkan War and World War II. After World War II, emigration was prohibited under communism.

Due to the abrupt end of communist isolationism and the ongoing recent war, there has been a significant flow of new arrivals since 1989. Fleeing their war torn region, about 450 Kosovars arrived in Massachusetts between May and September 1999.
Albanians arriving in the United States since this period have been noted to have had an especially difficult time with acculturation.

Geographic Locations:
The largest Albanian communities in Massachusetts are found around the Six Albanian Orthodox churches in South Boston, Natick, Worcester and Southbridge. Boston is the seat of the Albanian Archdiocese and has been, until recently, the largest community. Worcester is now becoming more attractive to newcomers, as the indigenous Albanians tend to be more active with resettlement assistance. A small community of Albanians has recently settled in Framingham. While some obtain Diversity Visa Lottery issues, most arrive with Tourist Visas. Due to the current hostilities in the Balkans, several have recently arrived as refugees.

Demographics:
Pre-World War II immigrants were mostly laborers and people with a low level of education. Most of the newer arrivals, a more professional group of individuals, were issued visas from the Diversity Visa Lottery (4,233 were granted to Albanians in 1997), which requires a GED for application.

As stated above, 450 Albanian refugees from the Kosovo region arrived in 1999.

Language/s Spoken:
The Albanian language is not derived from any other language—that is, it does not have a Slavic or Greek base as is commonly believed, but is one of the nine original Indo-European languages. As such, Albanian is one of Europe's oldest languages. The Albanian alphabet is Latin-based and similar to that of English except that it is comprised of 36 letters. The Albanians are essentially a homogenous people but have been divided traditionally into two basic groups, the Ghegs in the north and the Tosks in the south. Both Ghegs and Tosks speak the same language but pronounce it with some difference. Tosk is the official Albanian dialect.

Historical Background:
The Albanians are the direct descendants of the ancient Illyrians whose territories in 1225 BC included all of former Yugoslavia, including Dalmatia, Croatia, Bosnia, Herzegovina, Serbia, Montenegro, and portions of Macedonia and northern Greece. It was from one of the Illyrian tribes called the "Albanoi" located in central Albania, that the country derives its name. Albanians, however, call themselves "Shqipëtarë" and their country "Shqipëria;" meaning the "land of the eagles."

The Romans conquered Illyria in 227 BC. When the capital of the Roman Empire was transferred from Rome to Byzantium in 325 AD, Albania, then known as the Thema of Illyricum, became a province of the eastern section of the empire and remained part of the Byzantine Empire up until the early Middle Ages.

Certain feudal families then managed to form independent principalities that eventually evolved into a medieval *Arberia* (Albania)—including territories where the population was almost exclusively Albanian-speaking and Albanian in terms of history, laws, tradition and culture. The Ottoman conquest of Europe began in 1354 when the Turks captured the Byzantine fortress at Gallipoli. This military victory established their first stronghold on European soil. The defeat of the a Balkan coalition of Hungarians, Bulgarians, Romanians, Poles, Serbs, and Albanians on the plain of Kosova in 1389 marked the collapse of Serbia, Bulgaria, and Albania. Under Turkish rule, ethnic Albania was divided into four provinces or "vilayets"—including Shkodra, Kosova, Manastir, and Janina.

After the defeat of the Turks by the Russians in the war of 1877, the Great Powers revoked the Treaty of San Stefano the following year, signifying the break-up of the Ottoman Empire. The Great Powers penalized ethnic Albania because of its association with the Ottoman Empire for almost five centuries. As a result, the Albania of 1878 was divided by ceding major portions of the vilayet of Shkodra to Montenegro, the vilayet of Kosova to Serbia, the vilayet of Manastir to Macedonia, and the vilayet of Janina to Greece. Thus, what remained after the partitioning, is essentially the nation of Albania as it is known today.

Religion:
Up until the 16th century, almost all of Albania was Christian. The Orthodox religion was prominent in the south and the Roman Catholic in the north. In the 17th century, the Turks began a policy of Islamization by using, among other methods, economic incentives to convert the population. By the 19th century, Islam became predominant with about 70 percent of the population while some 20 percent remained orthodox and 10 percent Roman Catholic.

These groupings remained in effect until the communist government outlawed religion in 1967. Freedom of religion in Albania was restored only in 1989/90, but it must be noted that the overwhelming majority of Albania's population was born under a communist regime, which pursued an aggressively atheistic policy.

Although reliable statistics are lacking, it appears that the historical 70-20-10 percentages are no longer valid. The collapse of the old communist order has seen a religious revival of sorts,

and some now believe that the religion with the most new adherents in Albania are Christian evangelicals such as the Seventh Day Adventists, Jehovah's Witnesses, and others.

Even though frequently referred to as a "Muslim" country, there is no state religion in Albania, and the Albanians are renowned for their extraordinary religious tolerance. It is an often-overlooked fact that the Albanians protected their own Jews during the Holocaust while also offering shelter to other Jews who had escaped into Albania from Austria, Serbia and Greece.

Health Notes/Traditional Medical Practices:
Under communism, Albanian children were required to maintain their vaccinations. School age Albanian children in Massachusetts, newly arrived or born here, show a healthy basic medical record. The predominant health problem in the community is dental.

Mental Health Needs:
Fifty years of communist isolation, changes and growth after communism and the ensuing collapse of order in Albania has forced Albanians into a process of serious adjustment. Although mental health has attached to it a traditionally strong negative stigma, a need exists in the community for family and psychological therapy. Due to the war, Post-Traumatic Stress Disorder is common in newer arrivals.

Barriers to Access:
The most commonly cited barrier to accessing health services is difficulty with the English language and the lack of professional interpreter services. There is also a great unfamiliarity with the health care system in Massachusetts and with the idea of prevention as primary care. Lack of health insurance is a great obstacle to those seeking services, as is the alienation experienced in the health care settings where traditional family and medicinal practices are not recognized.

Additional Information:

Albania:
Republika e Shqipërisë

Capital:	Tiranha
Population:	3,364,571
Health:	Infant mortality rate: 42.9 deaths/1,000 live births
	Life expectancy—*Total population:* 69 years
	Male: 65.92 years *Female:* 72.33 years
Literacy:	*Total population:* 93%
	Male: N/A *Female:* N/A

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The Very Reverend Arthur Liolin, Chancellor of the Albanian Orthodox Archdiocese in America, Boston, MA.

The South Boston Community Health Center, Boston, MA.

Shkelqim Beqari, WBUR 90.9 FM, Boston, MA.

The Refugee and Immigrant Health Program, MA Department of Public Health.

Bosnians

Bosnian Population in Massachusetts:

1990 Census: U.S. / Ancestry	1990 Census: MA / Ancestry	2000 Community Estimate
N/A	N/A	9,000

* 1990 Census figures do not list figures for Bosnians.

Country/Region of Origin:
Bosnia and Herzegovina is the only republic of former Yugoslavia established on a geographical/historical basis rather than along ethnic lines. The ethnic groups that comprise Bosnia are 40% Serbian, 38% Muslim, and 22% Croat. Bosnia, approximately 2.5 times the size of Massachusetts, shares its borders with Croatia, Montenegro and Serbia.

Migration Trends:
Over 2 million people were displaced during the war. Refugees in Europe were granted Temporary Protective Status until a peace agreement was signed. Conditions in Bosnia since the signing of the peace agreement have not been conducive to successful refugee resettlement. Most of the refugees from Bosnia remain in Europe, with large numbers in Croatia and Macedonia. There are many Bosnian displaced persons, uprooted but remaining within Bosnia.

Since 1993, roughly 75,000 Bosnians have been resettled to the United States. Between 1993 and 1998, approximately 3,500 refugees arrived in Massachusetts. An estimated two thousand more have arrived since.

The 1990 Census lists a total statewide population of Croations at 2,535 and Serbians at 595.

Geographic Locations:
Most Bosnians that reside in the greater Boston area have been living in Chelsea, Revere, Everett, Brighton and Lynn. There are growing communities in Amherst, Holyoke, Springfield and small numbers in the Worcester area. Lately, there has been an influx of Bosnians settling in Malden, Somerville and Arlington.

Demographics:
New arrivals are mostly Muslims. There are also groups of ethnic Serbs, Croats and a high percentage of ethnically mixed marriages. A majority of the families have lived in urban centers.

Language/s Spoken:
Bosnian is the language formerly referred to as Serbo-Croatian, which includes the Bosnian, Serbian and Croatian languages. Minority groups speak Roman dialects (gypsy), Albanian and Ukrainian. Many Bosnians speak German and some speak English.

Historical Background:
Bosnia was part of the Roman province of Illyria and, like the rest of the Balkan region, was subsequently settled by Slavs during the 6th and 7th Centuries. Bosnia had its own language, "Bosancica", and its own church, whose followers were called "Bogomils" (Dear to God). It was Christianized in the 9th and 10th Centuries. After the split in the Roman Empire in the 11th Century, the border between Byzantium, which was Eastern Orthodox, and the West, which was Roman Catholic, divided Bosnia and would determine future events.

The region fell to the Ottoman armies in the early 15th Century and remained relatively isolated for 500 years. Many Bosnian Christians converted to Islam in this period. The Ottomans brought with them their traditions, religion, language, architecture, roads and the first water and sewage system in Europe.

By the 19th Century, much of Bosnia had become turbulent. Serbia won independence from Turkey. Repeated attempts at reform in the Ottoman Empire were unsuccessful and revolts grew. At the signing of the Treaty of San Stefano in 1878, Austria-Hungary took over the rule of Bosnia. This period brought to the state a new culture, architecture, health system and a school program.

During World War I, the Yugoslav peoples found themselves caught between the armies of Turkey and Austria-Hungary on the one hand, and those of Russia and the Great Powers on the other. In 1918, after World War I, the Kingdom of Serbs, Slovenes and Croats (a "first Yugoslavia") was created and administered by the royal family of Serbia. Bosnia was considered a multiethnic territory rather than an independent state. Islam was not recognized as a religion, and only became identified as a category in the official Bosnian census in 1971.

After World War II, Bosnia became a republic of Tito's Yugoslavia. Following Tito's break with Stalin in 1948, Yugoslavia enjoyed a period of growth and relative prosperity from the 1950's to the 1970's. Until its breakup, Yugoslavia's versions of "worker self-managed" Communism was relatively progressive. Its policy of nonalignment with either East or West established a degree of prestige for Yugoslavia in the Third World.

Upon Tito's death in 1980, the political system lacked his personal authority to settle questions of the allocation of resources to republics. In 1990, the Yugoslav Communist League dissolved following a progressive movement toward pluralism in the area that had resulted from the descent of communism. In May of 1991, Serb representatives blocked elections for the rotating presidency. In June, Slovenia and Croatia seceded from Yugoslavia. The Serbian minority then boycotted a referendum on independence for the remaining parts of Yugoslavia. The war began as Serbia, through its army of local militias and "demobilized" soldiers of the Yugoslav People's Army, embarked on a campaign aimed at eradicating non-Serbs from the area. Serbia was looking to create a Greater Serbia ("All Serbs united under a common state.", much like their vision of the Yugoslavia formed after the Yogoslav Movement at the turn of the 19th Century), and Croatia, a state of Herzeg-Bosna. As the Yugoslav war spread from Slovenia to Croatia, it became clear Bosnia could no longer remain outside the conflict.

From 1992:
Until its February 1992 independence, Bosnia and Herzegovina (hereinafter Bosnia) was part of Yugoslavia. Bosnia's population was then about 44 percent Bosnian, 31 percent Serbian, and 17 percent Croatian. The remaining population consisted of small numbers of other ethnic groups.

The Bosnian declaration of independence, following that of Slovenia and Croatia, led to the outbreak of war resulting in the elimination of ethnic groups from a conquered area, either by expulsion or massacre.

A peace agreement was signed in Paris on December 14, 1995. The agreement recognized Bosnia as a sovereign state within its present borders. It consists of two entities: a Muslim-Croat federation, over 51 percent of the territory, and the Bosnian Serb Republic, over 49 percent. The International Criminal Tribunal in the Hague has conducted trials, and won convictions, of individuals indicted for "crimes against humanity" during the ethnic cleansing campaign.

Family:
Parents usually do not speak English, often depending on their children to communicate. This creates a change in the family dynamics, where children gain a stronger role in the household because of their ability to speak English.

In the Bosnian Muslim tradition, roles for men and women are clear and separate, as was the home, which was designed with an area for the women and another for the men. Before WWII, women wore their traditional covering and were married by arrangement. After WWII, which brought an opening of social, educational and employment options for women, a newer family structure retained strong ties to roles which equated honorable standing in the community with adherence to tradition.

After WWII, Muslims, Catholics and Orthodox Serbs had the option of a civil or religious marriage ceremony. Many ethnically mixed marriages took place. Families continued to practice consultation with members – immediate and extended – before making major decisions. The separations caused by the war have adversely affected mixed families.

Religion:
The predominant religion in Bosnia is Islam, brought by the Ottoman Empire. The second largest is Serbian Orthodox, followed by Catholicism and Judaism. In cities like Sarajevo, where there were over 100 mosques, churches and synagogues, Bosnians often celebrated religious holidays together.

Health Notes/Traditional Medical Practices:
The Yugoslavian health system before the war was quite modern, with one doctor per 624 persons. Immunization for children was compulsory. The public health system and health conditions have deteriorated since 1992.

For the Muslim community, as seen in the Dervish orders, healing practices include scripture readings and other rituals for expelling illness from the body. Also, in urban areas especially, herbal remedies and naturopathic healing is still practiced.

Overseas medical screenings and initial health assessments of refugees from the former Yugoslavia who arrived in 1997 and 1998 found high blood pressure, cardio-vascular problems and physical and psychological disabilities caused by the war. Other findings include 51% were tuberculin skin test positive, 49% needed dental follow-up, 2% were positive for hepatitis B, and 91% had incomplete immunizations. Seven percent were anemic, with higher rates among children under 2 years of age. Sexually transmitted diseases (STD's) and HIV are areas of increasing concern. Cardiovascular disease is a major problem in this community. Of note is the fact that the traditional dietary pattern poses an increased cardiovascular risk to this population. Moreover, the level of consumption of alcohol and tobacco is also an area of concern.

Physical trauma components as a result of rape and other torture are becoming more prevalent; as is malnutrition, physical handicaps and other war related trauma.

Mental Health Needs:
Due to the war, many Bosnians suffer from post-traumatic stress disorder (PTSD), depression, anxiety-panic and phobic disorders and adjustment. Culturally and linguistically appropriate mental health services are needed.

Barriers to Access:
The most commonly cited barriers to accessing health services include the lack of professional interpreter services. Most Bosnians are not familiar with the concept of prevention and primary care. The lack of health insurance, difficulty in finding transportation and adequate childcare are all cited as barriers to accessing healthcare.
Many Bosnians are not used to the managed care system, and find it difficult to negotiate the health care system in this country. They resent what they consider a rushed visit at the clinician's office. In addition, they do not feel comfortable with what they perceive as intrusive questions. These mostly have to do with sexual behavior and drug use.

Additional Information:

Bosnia and Herzegovina:
Bosna i Hercegovina
(pre-war data)

Capital:	Sarajevo
Population:	4.5 million
Health:	Infant mortality rate: 24.52 deaths/1,000 live births
	Life expectancy—*Total population:* 66.98 years
	Male: 62.55 years *Female:* 71.71 years
Literacy:	*Total population:* 90% (urban areas) 50% (rural areas)

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Brazilians

Brazilian Population in Massachusetts:

1990 Census: U.S. / Ancestry	1990 Census: MA / Ancestry	2000 Community Estimate
65,876	7,483	170,000

* For more information on Portuguese speakers, see the chapters on the Cape Verdean and Portuguese communities.

Country of Origin:
Brazil occupies the Northeastern part of South America. It shares borders, from North to South, with French Guiana, Suriname, Venezuela, Colombia, Peru, Bolivia, Paraguay, Argentina and Uruguay.

Brazil is south of the equator and has a mostly tropical climate. Forests cover 65 percent of the country, including the world's largest tropical rain forest in the Amazon River Basin. Brazil's landscape is dominated by the Amazon River and central highlands.

Brazil is the 5th largest country in the world and the 6th most populous. It is larger than the continental United States and makes up half of the continent of South America. Sixty-two percent of the population is under the age of 29. Brazilians of European descent (mostly Portuguese) make up 55 percent of the population, while 39 percent are of mixed heritage, 10 percent have African ancestry and 0.5 percent are of Japanese origin. The Indigenous population is estimated at 150,000, many of whom inhabit the Amazon region.

Migration Trends:
Brazilians have most recently been arriving in substantial numbers due primarily to poverty and lack of economic opportunity in their homeland.

Geographic Locations:
Brazilians are concentrated in the Boston area, on Cape Cod and in Central Massachusetts—including Framingham, Marlborough and Hudson. There are also large communities in Lowell, East Boston, Lowell, Rockland and Stoughton.

Demographics:
New Brazilian arrivals tended to be younger adults and often low-income individuals. Recently, however, there has been a substantial increase of middle class Brazilian settling in the Massachusetts area.

Language/s Spoken:
Portuguese is Brazil's official language. English, Spanish, German and French are popular second languages. The indigenous populations speak a variety of more than 100 Amerindian languages. Brazil is the only Portuguese speaking country in South America. The Brazilian language is sometimes described as a mix of Portuguese, African and indigenous languages.

Historical Background:
In 1500, Pedro Alvares Cabral landed in Brazil and claimed the region for Portugal. Both the French and Dutch tried to establish colonies; the Spanish controlled the region from 1580 to 1640, when it was returned to the Portuguese regime. Dom Pedro II, who was governing the land at the time, declared Brazil's independence in 1822.

The Portuguese developed their new lands for centuries by bringing in African slaves. By the end of the 19th Century, slavery declined as a workable system due to immigrant laborers, whose wages cost less than owning slaves. This, the British long time anti-slave trade policies (intended to assist sugar production in British colonies) and pressure from abolitionists contributed to the signing of the "Golden Law" (Lei Áurea) in 1888, abolishing slavery. In 1889, without bloodshed, the Emperor was deposed and a Republic was established.

Political, social and economic unrest created a crisis in the country in the early 1960's. In 1964, General Castelo Branco led a coup with the intention of stabilizing the political and economic situation. By 1968, inflation was contained, but the government became increasingly repressive. Between 1967 and 1972, Brazil enjoyed a great rate of economic growth, and 1972 marked the beginning of the "abertura," the process of restoring rights. In 1982, the country held state government elections for the first time since 1965.

Religion:
About 73 percent of the population is Roman Catholic. There are, however, followers of mainstream Protestant denominations from Europe and the US such as Episcopal, Methodist, Lutheran and Baptist, and over 1.5 million Spiritists, or Kardecists, who follow the doctrine of 19th Century French psychic researcher, Allen Kardec. Small minorities include Jews, Moslems and Buddhists.

Candomblé is practiced throughout Brazil. It is a religion that was brought by Yoruba slaves from Nigeria and Benin. Brazilians from every social and economic group participate in both Catholicism and Candomblé.

Slave owners and Catholic officials, in an attempt to convert African slaves, prohibited traditional African rituals. In order to continue their practices, Africans coupled their animistic deities with corresponding Catholic personalities. Oxalá, a male god of procreation and harvest, for instance, was identified with Jesus; Iemanjá, goddess of the sea, is associated with "Our Lady of Conception." Throughout the year, the two religions had many corresponding festivals. In this way, the Catholic Church was appeased and Africans were able to celebrate their religion.

In Massachusetts, there are nine organized parish groups under the Brazilian Apostolate Archdiocese of Boston. These groups meet in the following towns: Allston, Caambridge, East Boston, Somerville, Stoughton, Rockland, Marlborough, Framingham, and Lowell.

Health Notes/Traditional Medical Practices:
Excellent medical care is available in Brazilian cities for those who can afford it. Other areas are, however, are rarely equipped with adequate facilities. Water is often not potable and sanitation in some areas is insufficient.

Brazilians often seek spiritual healing. It is common for them to seek a remedy trough prayer, and in turn, exclude medical treatment. Unintentional misuse of prescriptions is also common.

Mental Health Needs:
It is common to see women and men with reactive depression due to the stresses of immigration, separation from family, and arduous work schedules.

The community has identified domestic violence and alcohol abuse as major health concerns.

Barriers to Access:
The most commonly cited barriers to accessing health services include the lack of professional interpreter services, unfamiliarity with the US health care system, the concept of prevention and primary care, and lack of health insurance.

Additional Information:

Brazil:
República Federativa de Brasil

Capital:	Brasília
Population:	171,853,126
Health:	Infant mortality rate: 35.37 deaths/1000 live births
	Life expectancy—*Total population:* 64.06 years
	Male: 59.35 years *Female:* 69.01 years
Literacy:	*Total Population:* 83.3%
	Male: 83.3% *Female:* 83.2%

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Cape Verdeans

Cape Verdean Population in Massachusetts:

1990 Census: U.S. / Ancestry	1990 Census: MA / Ancestry	2000 Community Estimate
50,772	29,326	70,000

* For more information on Portuguese speakers, see the chapters on the Brazilian and Portuguese communities.

Country of Origin:
The Cape Verde, or Cabo Verde, archipelago consists of a group of 10 islands and five islets, located 385 miles off the West Coast of Africa. Sand carried by high winds has caused erosion on all islands. Sheer, jagged cliffs rise from the sea on several of the mountainous islands. The lack of natural vegetation in the uplands and coast also contributes to soil erosion. Rainfall is irregular, historically causing periodic droughts and famines.

The Cape Verde archipelago was uninhabited until the Portuguese discovered it in 1456. African slaves were brought to the islands to work on Portuguese plantations. As a result, Cape Verdeans have mixed African and European origins. Survival in a country with few natural resources historically has induced Cape Verdeans to emigrate. Of the more than one million people of Cape Verdean ancestry in the world, only a little more than one-third actually live on the islands.

Migration Trends:
Cape Verdeans have historically emigrated for economic reasons. The first wave settled in the fishing/whaling ports and mill towns of New England. By the early 20th century, Cape Verdean communities were well established in the United States.

Geographic Locations:
Significant numbers of Cape Verdeans are located in the Boston, New Bedford, Brockton and Cape Cod areas.

Language/s Spoken:
Although the official language is Portuguese, most Cape Verdeans speak a Creole dialect—Crioulo—which consists of archaic Portuguese modified through contact with African and other European languages.

Historical Background:
In 1492, Portuguese settlers arrived at Santiago and founded Ribeira Grande (Cidade Velha) – the first permanent European settlement city in the tropics. In the 16th century, the archipelago prospered from the transatlantic slave trade.

The archipelago has experienced recurrent drought and famine since the end of the 18th century, and with the decline of the slave trade, its fragile prosperity slowly vanished. However, the islands' position astride mid-Atlantic shipping lanes made Cape Verde an ideal location for re-supplying ships. Because of its excellent harbor, Mindelo (on the island of São Vicente) became an important commercial center during the 19th century.

In an attempt to blunt growing nationalism, Portugal changed Cape Verde's status from a colony to an overseas province in 1951. Nevertheless, in 1956, Amilcar Cabral, a Cape Verdean, and

Rafael Barbosa organized (in Guinea-Bissau) the clandestine African Party for the Independence of Guinea-Bissau and Cape Verde (PAIGC). Together, they demanded for improvements in the economic, social, and political conditions in Cape Verde and Portuguese Guinea and formed the basis of the two nations' independence movement. PAIGC began an armed rebellion against Portugal in 1961. Acts of sabotage eventually grew into a war in Portuguese Guinea.

In December of 1974, the PAIGC and Portugal signed an agreement providing for a transitional government composed of Portuguese and Cape Verderans. On June 30, 1975, Cape Verdeans elected a National Assembly, and days later received full independence.

In 1990, an emergency congress was called to discuss proposed constitutional changes to end one-party rule. Subsequently, the one party state was abolished, and the first multi-party elections were held in January 1991.

Religion:
Cape Verde is a predominately Roman Catholic (infused with indigenous beliefs).

Family:
Cape Verdeans value a strong immediate and extended family.

Health Needs/Traditional Medical Practices:
Medical attention is often sought only in cases of serious illness or injury. Service providers cite high blood pressure, diabetes and cancer as common health problems. Domestic violence is also a serious community concern. Self-medication, holistic and religious practices are preferred to modern medical techniques. New arrivals are at risk for tropical illnesses such as malaria, or "paludismo."

Cape Verdeans hold steadfast to holistic remedies. Various teas, herbs, oils and creams are used for treating most illnesses.

Mental Health Needs:
The family—immediate and extended—serves as support for psychological well being. Alcohol abuse is a common problem, but many individuals prefer to seek spiritual counseling over any other form of treatment.

Barriers to Access:
The most commonly cited barriers to accessing health services include the lack of professional interpreter services, unfamiliarity with the US health care system, lack of health insurance and with the concept of prevention and primary care.

Additional Information:

Cape Verde:
Cabo Verde

Capital:	Praia
Population:	405,748 (July 1999 est.)
Health:	Infant mortality rate: 45.5 deaths/1,000 live births (1999 est.)
	Life expectancy—*Total population:* 70.96 years
	Male: 67.66 years *Female:* 74.3 years
Literacy:	*Total population:* 71.6%
	Male: 81.4% *Female:* 63.8%

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Z. Araujo, Cross Cultural Communications, Inc., Winchester, Massachusetts.

Central Americans

Central American Population in Massachusetts:

Country of Origin	1990 Census: U.S. / Ancestry	1990 Census: MA / Ancestry	2000 Community Estimate
El Salvador	499,153	7,835	N/A
Guatemala	241,559	5,866	N/A
Honduras	116,635	3,155	N/A
Nicaragua	177,077	591	N/A
Total:	1,034,244	17,447	85,000

Country of Origin:
Central American migrants primarily come from El Salvador, Guatemala, Honduras and Nicaragua.

Migration Trends:
Central American migration to the United States began to increase rapidly in 1979. This was due to the civil unrest that was taking place in several Central American countries: particularly in El Salvador and Guatemala. More recently, there has been a leveling off of migration to Massachusetts.

Legalization (or Amnesty): In 1986, the passage of the Immigration Reform and Control Act (IRCA) permitted certain undocumented non-citizens to obtain legal immigration status based on having lived continuously in the U.S. since before 1982, or having a particular history of agricultural work in the U.S. A great number of Central Americans in Massachusetts were able to benefit from IRCA.

Temporary Protected Status (TPS): As part of the Immigration Act of 1990, Congress enacted a law creating temporary protected status (TPS) for certain non-citizens. These individuals would have last resided in countries where either on-going armed conflict made it unsafe for the person to return, a natural catastrophe had occurred which seriously disrupted normal living and working conditions, or some other "extraordinary and temporary" condition made it unsafe for them to return. This status was made available to Salvadorans residing in the U.S. before 1990. Hondurans and Nicaraguans affected by Hurricane Mitch were granted Temporary Protected Status if they have been in the U.S. since 1999. With this TPS status, they are currently allowed to remain here through July 5, 2001.

Deferred Enforced Departure (DED) replaced TPS for Salvadorans when the TPS Program for them ended. This status was similar to TPS in that it allowed grantees to work and live legally in the United States until they were registered in the *ABC* program.

In December 1990, the *American Baptist Church ("ABC") settlement agreement* recognized the significant discrimination, which had occurred in the adjudication of asylum applications, filed by Salvadorans and Guatemalans. It required that the Immigration and Naturalization Service (INS) establish new and fair procedures for adjudicating class members' claims. The settlement further provided that ABC class members could reside and work legally in the U.S. as long as their asylum claims were pending. Some cases were approved for asylum under this program while others remain pending in an INS backlog due to other developments, such as NACARA enactment (see below).

NACARA (the Nicaraguan Adjustment and Central American Relief Act): On November 19, 1997, President Clinton signed into law legislation that provides various forms of immigration benefits and relief from deportation to certain Central Americans, Cubans and nationals of former Soviet bloc countries. The benefits contained in the new legislation will apply to individuals in all stages of immigration proceedings. Under NACARA, Cubans and Nicaraguans have the right to apply for Legal Permanent Residency (LPR) if they entered the U.S. before December 12, 1995. Guatemalans and Salvadorans in the ABC program must apply for Suspension of Deportation. Other Guatemalans and Salvadorans may also apply for Suspension of Deportation if they applied for asylum before April 1, 1990, as may certain dependents of NACARA-eligible persons. If Suspension of Deportation is granted, they will be given LPR status.

Geographic Locations:
Most Central Americans are living in the East Boston, Jamaica Plain, Allston/Brighton, Cambridge, Chelsea and Somerville. There is also a growing population of Central Americans in Holyoke, Springfield, Lawrence, Lowell, Lynn and Brockton.

Demographics:
The Central American population in the Commonwealth consists primarily of young adults and is somewhat more male than female. An increasing number of women have immigrated, resulting in the expansion of families and the number of babies being born on U.S. soil. Many come from rural areas and have limited educational opportunities and few transferable job skills. A sizeable percentage of refugees are not literate in Spanish. Recently, due to family reunification, more educated individuals are arriving.

Language/s Spoken:
Spanish and Indigenous languages (there are 21 Spanish dialects in Guatemala as well as Indigenous languages spoken there and in El Salvador).

Religion:
Mainly Roman Catholic and Protestant.

Health Notes/Traditional Medical Practices:
There is a great need in the Central American community to access appropriate health services and information. A large percentage of refugees from Guatemala and El Salvador have risk factors for cardiovascular disease. Many arrive without adequate immunizations. There is also a high incidence of diabetes mellitus in the community.

As a result of the physical and psychological stress sometimes endured while leaving their native countries, combined with a previous lack of adequate medical care, many have suffered from malnutrition, lack of prenatal care, parasitic infections and tuberculosis infection (there are small numbers of active tuberculosis, compared with TB infection). Consequently, under the stresses associated with immigration, they are at increased risk for development of active TB.

Traumatic pasts, separation from families, stresses of acculturation, lack of traditional supports and the easy availability of both drugs and alcohol in this country have contributed to alcohol and drug abuse, as well as instances of domestic violence.

Mental Health Needs:
Mental Health is a taboo subject in the Central American community. There is a lack of information about available services, and individuals may avoid seeking any for fear of being rejected by their community. Those who do seek services bring a wide variety of symptoms, including depression, post-traumatic stress disorder, separation anxiety, a sense of isolation and suicidal behavior. Some refugees have been victims of torture and other horrors stemming from violent conflict.

Barriers to Access:
The most commonly cited barriers to accessing health services include the lack of professional interpreter services, unfamiliarity with the U.S. health care system, the concept of prevention and primary care and lack of health insurance.

Many Central Americans without documented status may avoid public facilities, including hospitals and health centers, due to the fear of being deported. The desire for anonymity often precludes utilization of services and benefits available to residents of the Commonwealth.

Additional Information:

El Salvador:
República de El Salvador

Capital:	San Salvador
Population:	5,839,079
Health:	nfant mortality rate: 30 deaths/1,000 live births
	Life expectancy—*Total population:* 70.02 years
	Male: 66.7 years *Female:* 73.5 years
Literacy:	*Total population:* 71.5%
	Male: 73.5% *Female:* 69.8%

Guatemala:
República de Guatemala

Capital:	Guatemala City
Population:	12,335,580
Health:	nfant mortality rate: 49 deaths/1000 live births
	Life expectancy—*Total population:* 66.45 years
	Male: 63.78 years *Female:* 69.24 years
Literacy:	*Total population:* 55.6%
	Male: 62.5% *Female:* 48.6%

Honduras:
República de Honduras

Capital:	Tegucigalpa
Population:	5,997,327
Health:	Infant mortality rate: 40.84 deaths/1000 live births
	Life expectancy—*Total population:* 64.68 years
	Male: 63.16 years *Female:* 66.27 years
Literacy:	*Total population:* 72.7%
	Male: 72.67% *Female:* 72.7%

Nicaragua:
República de Nicaragua

Capital:	Managua
Population:	4,717,132
Health:	Infant mortality rate: 40.47 deaths/1,000 live births
	Life expectancy—*Total population:* 67.08 years
	Male: 64.7 years *Female:* 69.56 years
Literacy:	*Total population:* 65.7%
	Male: 64.6% *Female:* 66.6%

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Chinese

Chinese Population in Massachusetts:

Country of Origin	1990 Census: U.S. / Ancestry	1990 Census: MA / Ancestry	2000 Community Estimate
Chinese	1,505,245	47,245	N/A
Cantonese	25,020	952	N/A
Taiwanese	192,973	4,401	N/A
Total:	1,723,238	52,598	75,000

Countries/Regions of Origin:
Territories include mainland China, Hong Kong, and Taiwan. Located in Eastern Asia, these territories border the East China Sea, Korea Bay, Yellow Sea, and the South China Sea. The largest ethnic group is the Han Chinese, who constitute about 91.9% of the total population. The remaining 8.1% are Zhuang (16 million), Manchu (10 million), Hui (9 million), Miao (8 million), Uygur (7 million), Yi (7 million), Mongolian (5 million), Tibetan (5 million), Buyi (3 million), Korean (2 million), and other ethnic minorities. Taiwan has a population of 21.5 million. More than 18 million, the "native" Taiwanese are descendants of Chinese who migrated from Fujian and Guangdong Provinces on the mainland, primarily in the 18th and 19th centuries. The "mainlanders," who arrived on Taiwan after 1945, came from all parts of mainland China. About 370,000 aborigines inhabit the mountainous central and eastern parts of the island and are believed to be of Malayo-Polynesian origin.

China is facing serious environmental and public health issues caused in large part by air pollution from the overwhelming use of high-sulfur coal as fuel by individuals and industry. Growth in water usage threatens to out pace the water supply. A sizeable amount of the population does not have access to potable water.

Migration Trends:
The 1966 Immigration Act nullified previous immigration laws that were particularly discriminate towards those of Asian decent. After its passing, a sudden influx of Chinese immigrants settled in Massachusetts. Unlike their Chinese predecessors who planned on eventually returning to their native land, new immigrants, driven by civil turmoil and political persecution at home, looked to build a permanent home base.

Demographics:
The first Chinese to settle in Massachusetts were merchants and seamen engaged in an active trade between China and the United States during the 19th century. Trade with China was halted, however, when the Communists came to power in 1949. Due to the globalization of business and international trade, however, trade and emigration between the two countries has resumed.

Laborers were the second major group to settle in Massachusetts. Originally brought in to break a strike at a shoe factory in North Adams, they settled in Boston near South Station once their contract expired. They found work helping to build the Pearl Street Telephone Exchange Building. Thereafter, many opened or worked in hand laundries and restaurants scattered throughout New England. With the end of discriminatory immigration laws in the mid-1960s, many of these laborers were able to bring their families to Massachusetts.
Scholars were the third major group to settle in Massachusetts. Western science and technology had great appeal to the Chinese emperor late in the 19th century. A program was

set up to bring young Chinese boys to study in the United States, who then returned to China so they could apply their newly-gained knowledge and skills. American colleges and universities have continued to attract Chinese students, but because of the political situation in their home countries and of limited opportunities to use their advanced knowledge, many have stayed in the United States.

With the end of the Vietnam War, the U.S. government made provisions for many political refugees from Southeast Asia to settle in the United States. Included in this group were ethnic Chinese from Cambodia, Laos and Vietnam.

The most recent group to arrive is those from the province of Fukien. A number from this ethnic group paid huge sums for passage to the United States and may be in debt to their smugglers. Because so few social service workers speak their dialect and because of their undocumented status, they are very much without support and are at risk.

According to the 1990 Census, there are over 50 Asian Pacific American groups.

Geographic Locations:
In Boston, many Chinese immigrants reside in Chinatown. The second largest community is in Quincy. The South End, Allston/Brighton, Brookline, Cambridge, Chelsea, Lexington, Lowell, Lynn, Malden, Newton and Randolph also contain a significant number of Chinese as well.

Language/s Spoken:
There are seven major Chinese dialects and many subdialects. Mandarin (or Putonghua), the predominant dialect, is spoken by over 70% of the population. It is taught in all schools and is the medium of government. About two-thirds of the Han ethnic group are native speakers of Mandarin; the rest, concentrated in southwest and southeast China, speak one of the six major Chinese dialects. Non-Chinese languages spoken widely by ethnic minorities include Mongolian, Tibetan, Uygur and other Turkic languages (in Xinjiang), and Korean (in the northeast).

Historical Background:
For most of its 3,500 years of history, China led the world in agriculture, crafts, and science, then fell behind in the 19th century when the Industrial Revolution gave the West clear superiority in military and economic affairs. In the first half of the 20th century, China continued to suffer from major famines, civil unrest, military defeat, and foreign occupation. After World War II, the Communists under MAO Zedong established a dictatorship that, while ensuring China's autonomy, imposed strict controls over all aspects of life and cost the lives of tens of millions of people. After 1978, his successor DENG Xiaoping decentralized economic decision making; output quadrupled in the next 20 years. Political controls remain tight at the same time economic controls have been weakening. Present issues are: incorporating Hong Kong into the Chinese system; closing down inefficient state-owned enterprises; modernizing the military; fighting corruption; and providing support to tens of millions of displaced workers.

Religion:
Although officially atheist, religion plays a significant part in the life of many Chinese. Buddhism is most widely practiced, with an estimated 100 million adherents. Traditional Taoism also is practiced. Official figures indicate there are 18 million Muslims, 4 million Catholics, and 10 million Protestants; unofficial estimates are much higher.

Family:
The Chinese family is usually made up a hierarchy consisting of the grandparents, parents, and children. Each family member has his/her prescribed role, and the older the member, the more social power s/he possesses. The immigration process, however, tends to complicate the situation. The children may become more powerful since they can adapt easier to the western culture and language. The elders are left alone at home while the other members go out to work. Wives may be the bread winner since they can find jobs with greater ease than their husbands. Hence, males lose their traditional "provider" status.

Health Notes/Traditional Medical Practices:
Some Chinese turn to traditional Chinese medicine and take Chinese herbs for chronic ailments. This may conflict with western medicine practices. Providers are encouraged to ask whether their patients are using alternative remedies in conjunction with, or in place of, prescribed drugs.

Illnesses prevalent in the Chinese community include hypertension, tuberculosis, hepatitis and hepatitis B, diabetes, kidney disease, thalassemia, pneumonia, influenza and chronic obstructive pulmonary disease.

Traditional Chinese Medicine (TCM) has been practiced in Asia for over 5,000 years. The philosophy behind TCM is holistic health care, from diagnosis to treatment to maintenance. TCM works to regenerate the organ functions in one's body. Bringing bodily functions into balance while increasing its natural immune system restores health. Traditional Chinese herbalists are equivalent to pharmacists, spending time with their customers to find out exactly what the health problems are before prescribing treatment. Thousands of herbs have been categorized and classified according to the properties they contain. Formulas are made from specific combinations that are used to treat specific illnesses.

Helpful Information from Midtown Health Care, Inc., Boston:
- Provide reassurance and detailed explanation on blood drawing, lumbar puncture, invasive procedures and surgery.
- Do not completely disrobe patients, especially females.
- History and age reported may not be completely accurate.
- Be aware that some time may be needed to establish trust.
- Do not schedule elective admission/surgery around major holidays such as the New Year.
- Serve hot or warm fluids or food.
- Engage family members in decision making.
- Provide appropriate interpreter services.
- Understand that the patient may be using both traditional and western treatments at the same time.

Mental Health Needs:
Mental health is a taboo topic among the Chinese mainly due to the misunderstanding that mental illness is the same as "insanity." Mental health is often not openly talked about because many consider it to be a personal issue. The western mode of psychotherapy does not compliment the Chinese mode of expression and so many Chinese are reluctant to seek mental health care.

Many new immigrants encounter mental health issues relating to the immigration process—including culture shock, adjustment issues, role reversal, and intergenerational and marital conflicts. The current lack of bilingual clinicians also adds to the difficulties of assessing services.

Barriers to Access:
The most commonly cited barriers to accessing health services include the lack of professional interpreter services, unfamiliarity with the U.S. health care system, the concept of prevention and primary care and lack of health insurance.

Financial factors are also a major barrier since most of the new immigrants are not employed in jobs that provide health insurance. They may also not be eligible for federal or state assistance. For these reasons, they usually delay seeking medical help.

The Chinese in Massachusetts need more access to appropriate health services and information. The Asian community is highly diverse; non-Chinese residents may make use of services in Chinatown to have access to a more familiar environment. Primary care services are available in Cantonese, Mandarin, Toisanese and other dialects at the South Cove Community Health Center and through several private practice physicians. Appropriate hospital care and specialty care is not easily acquired, although several institutions are trying to adapt their services to meet the needs of the Chinese community.

Additional Information:

People's Republic of China:
Zhonghua Renmin Gongheguo

Capital:	Beijing
Population:	1,246,871,951
Health:	Infant mortality rate: 43.31 deaths/1000 live births
	Life expectancy—*Total population:* 69.92 years
	Male: 68.57 years *Female:* 71.48 years
Literacy:	*Total population:* 81.5%
	Male: 89.9% *Female:* 72.7%

Hong Kong Special Administrative Region:
Xianggang Tebie Xingzhengqu

Capital:	Victoria
Population:	6,847,125
Health:	Infant mortality rate: 5.2 deaths/1000 live births
	Life expectancy—*Total population:* 78.91 years
	Male: 76.15 years *Female:* 81.85 years
Literacy:	*Total population:* 92.2%
	Male: 96 % *Female:* 88.2%

Taiwan:

Capital:	Taipei
Population:	22,113,250
Health:	Infant mortality rate: 6.01 deaths/1,000 live births
	Life expectancy –*Total population:* 77.49 years
	Male: 74.38 years *Female:* 80.85 years
Literacy:	*Total population:* 84%
	Male: 93% *Female:* 79%

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Chinese Historical Society, Boston, MA.
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Dr. Chung, T., Executive Office of Elder Affairs, Boston.
Prof. Leong, A., University of Massachusetts, Boston

Colombians

Colombian Population in Massachusetts:

1990 Census: U.S. / Ancestry	1990 Census: MA / Ancestry	2000 Community Estimates
351,717	3,869	27,500

Based on the 1990 US Census, Colombians constitute approximately 10 percent or 27,500 of the 275,000 Latinos in Massachusetts. Because the census is least likely to count people whose legal residency status is not established, as well as newcomers who are unacculturated and speak little English, the percentage is probably underrepresented. Since 1995, according to Immigration and Naturalization Service (INS) statistics, about 10,838 Colombians have immigrated to the United States.

Country of Origin:
The Republic of Colombia is located in Northern South America, bordering the Caribbean Sea and the North Pacific Ocean. The country is roughly about the size of Montana.

Colombia is the third-most populous country in Latin America, after Brazil and Mexico. Movement from rural to urban areas has been heavy. The urban population increased from 57% of the total population in 1951 to about 74% by 1994.

The ethnic diversity in Colombia is a result of the intermingling of indigenous Indians, Spanish colonists, and African slaves. Today, only about 1% of the people can be identified as fully Indian on the basis of language and customs. Unlike several other South American countries, few foreigners have immigrated to Colombia.

Migration Trends:
Colombians began to migrate to the United States in the 1950s and early 1960s. Coming mainly from the capital of Santa Fé de Bogotá, Colombians sought employment opportunities in factories, as domestic help and as baby-sitters. In particular, textile mills in Lowell and Lawrence attracted weavers from Colombia, who were known for their excellent craft. During this period, many Colombians were able to obtain permanent residency and employment contracts. This migration trend tapered off gradually.

Due to the political turmoil and insecurity of the time, a large influx of Colombians arrived from the cities of Cali and Medellin in the 1970s and 1980s. The Medellin and Cali drug cartels drove Colombians from their homes and land, causing the economic downturn of many businesses. As a result, many Colombians have arrived with undetermined legal status.

In addition, during the 1970s and 1980s, a large percentage of Colombians students participated in exchange programs at Harvard University, Boston University, Boston College, Northeastern University and other local schools. Many professionals came to the Massachusetts area to pursue graduate and post-graduate studies.

During the 1990s, violence by paramilitary groups and armed conflict between the Colombian armed forces, guerilla groups and paramilitaries has continued to increase displacement.

Geographic Locations:
Most Colombians reside in Boston (East Boston, Brighton), Lowell, Brockton, Springfield, Chelsea, Worcester, Waltham and Holyoke.

Demographics:
A number of Colombian residents have integrated into mainstream America. Many have become U.S. citizens, working in professional careers, the human services sector, office support and clerical. Seventy percent are working class, and a number are self-employed—owning grocery stores, travel agencies, and other small businesses. In addition, there is a significant Colombian student and professional population pursuing undergraduate, graduate and post-graduate studies.

A large percentage of the Colombians in Massachusetts are from Antioquia (the Medellin region), Bogota and Barranquilla.

As of 1996, the INS stated that Colombia ranks twelfth among the top countries of undocumented residents.

Language/s Spoken:
Spanish and various indigenous dialects.

Historical Background:
Conquered by the Spanish in 1530s, the region that is now Colombia became the core of the Spanish colony of New Granada—included Panama and most of Venezuela. The struggle for independence from Spain began in 1810, lasted nine years, and ended with a victory lead by Simón Bolívar at Boyacá in 1819. Bolívar set up the new state of Greater Colombia—included all of New Granada and Ecuador. Political differences soon emerged, however, and the union fell apart. Venezuela and Ecuador became separate nations; the remaining territory eventually became the Republic of Colombia (1886), from which Panama seceded in 1903.

Through the 19th and into the 20th century, political unrest and civil strife rocked Colombia. Strong parties developed along conservative (centrist) and liberal (federalist) lines, and civil war frequently erupted between the factions. As many as 100,000 people were killed before the conservatives emerged victorious in a civil war of unprecedented violence that raged from 1899 to 1902. In 1948, after a four-decade hiatus of political peace, bloody strife spread throughout the nation, costing hundreds of thousands of lives. Orderly government was finally restored as the result of a compromise between liberals and conservatives in 1958.

A guerrilla insurgency, however, arose in the 1970s and continued well into the 1990s. Also during this time period, the cocaine cartels threatened to undermine civil government through bribery, bombings, kidnappings, and the murder of government officials. In the 1990 presidential election, an outspoken enemy of the drug lords, César Gaviria Trujillo, was elected president. Although the power of the notorious Medellín drug cartel was broken in 1993, the Cali cartel remains strong. The Liberal party candidate, Emesto Samper Pizano, won the presidency in 1994, but his victory was tarnished by allegations that his campaign had accepted money from drug traffickers.

On August 7, 1998, Andres Pastrana was sworn in as the President of Colombia. A member of the Conservative Party, Pastrana defeated Liberal Party candidate Horacio Serpa in a run-off election marked by high voter turn-out and little political unrest. In an August visit with President Clinton, then President-elect Pastrana expressed his hopes for bringing about a peaceful resolution of Colombia's long-standing civil conflict, and conveyed his commitment to cooperate fully with the United States to combat the traffic in illegal drugs.

Religion:
Roman Catholic 95%

Health Notes/Traditional Medical Practices:
Health problems include substance abuse (alcohol, other drugs and tobacco), HIV/AIDS, diabetes, high blood pressure, cancer and domestic violence.

Mental Health Needs:
Common mental health problems among Colombian newcomers include post-traumatic stress syndrome and depression.

Barriers to Access:
The most commonly cited barriers to accessing health services include the lack of professional interpreter services, unfamiliarity with the U.S. health care system, the concept of prevention and primary care and lack of health insurance.

Additional Information:

Colombia:
República de Colombia

Capital:	Santa Fé de Bogotá
Population:	39,309,422
Health:	Infant mortality rate: 24.5 deaths/1000 live births
	Life expectancy—*Total population:* 70.48 years
	Male: 66.54 years *Female:* 74.54 years
Literacy:	*Total population:* 91.3%
	Male: 91.2% *Female:* 91.4%

References:

Latino Health Institute
Famighetti, Robert, ed. *The World Almanac.* Funk and Wagnalls, Mahwáh, NJ, 1994.
U.S Committee for Refugees, www.refugees.org/who/whomain/htm.

Congolese

Congolese Population in Massachusetts:

1990 Census: U.S. / Ancestry	1990 Census: MA / Ancestry	2000 Community Estimate
N/A	N/A	2000

Country of Origin:
The Democratic Republic of the Congo (DROC), formerly Zaire, includes the greater part of the Congo River Basin, which covers an area of almost 1 million square kilometers (400,000 sq. mi.). DROC lies on the Equator, with one-third of the country to the north and two-thirds to the south. The population of DROC was estimated at 46.7 million in 1997, with as many as 250 ethnic groups distinguished and named. The most numerous people are the Kongo, Luba, and Mongo.

Migration Trends:
The Congolese started to arrive in the United States soon after their country gained independence from Belgium. While some arrived independently, most of them were students who came on scholarships. For the most part, the population initially consisted of students and their families. Recently, however, many refugees have arrived because of the war that is going on in the east of the country.

Geographic Locations:
There are large populations of Congolese in Illinois, Texas, Ohio, North and South Carolina, California, Washington D.C., New York and Massachusetts. It is estimated that there are about 2000 Congolese in Massachusetts. Most live in Boston, Lynn, Framingham, Lawrence and Brighton.

Languages:
Although 700 local languages and dialects are spoken, the linguistic variety is bridged both by the use of French and the intermediary languages Kikongo, Tshiluba, Swahili, and Lingala. Most Congolese speak two or three of these languages.

Religion:
About 80% of the Congolese population are Christian (predominantly Roman Catholic). Most of the non-Christians adhere to either traditional religions or syncretic sects. Traditional religions embody such concepts as monotheism, animism, vitalism, spirit and ancestor worship, witchcraft, and sorcery and vary widely among ethnic groups; none is formalized. The syncretic sects often merge Christianity with traditional beliefs and rituals. The most popular of these sects, Kimbanguism, was seen as a threat to the colonial regime and was banned by the Belgians. Kimbanguism, officially "the church of Christ on Earth by the prophet Simon Kimbangu," now has about 3 million members, primarily among the Bakongo of Bas-Congo and Kinshasa. In 1969, it was the first independent African church admitted to the World Council of Churches.

Family:
The extended family is the base of the Congolese society. To the Congolese, children are considered the bridge to the future and therefore the center of Congolese life.

Historical Background:
Prior to May 1997, the country had a highly centralized presidential executive system, with the president elected to a seven-year term. Rebel leaders who seized power in 1997 had promised a constitutional referendum and democratic elections by mid-1999. By most accounts, however, the leadership has transformed into a dictatorship.
After independence from Belgian rule in 1960, the Republic of the Congo was proclaimed with Patrice Lumumba as Prime Minister, following national elections. He then went on to form a coalition cabinet. Widespread violence resulted in the murder of Lumumba in 1961 after his removal from office. The strife continued until 1965.

In late 1965, a former leader of the Congolese army, Colonel Joseph Désiré Mobutu (later Mobutu Sese Seko) became president. In his first year as president, Mobutu brought political stability to the country, although there were a number of short-lived regionally based revolts. In 1990 Mobutu legalized opposition parties. Nevertheless, popular discontent grew in the early 1990s as the economy deteriorated, and government corruption continued. Outbreaks of violence and looting led many European and American civilians to flee the country. With the influx of refugees from the massive violence in Rwanda, ethnic conflict was heightened. In Eastern Congo, the Rwandan refugees, who were predominantly Hutu, were engaged in conflict with Congolese rebels, mostly Tutsis. Anti-Mobutu rebels from the East finally overthrew Mobutu in May 1997. The country was renamed the Democratic Republic of the Congo and rebel leader Laurent Désiré Kabila became president. Civil strife has continued as rebels seek to oust Kabila. Consequently, internal displacement and a refugee outflow continues to persist.

Although most Rwandan refugees have returned to Rwanda during the violence in the Congo, there are still refugees from Rwanda, Angola, Burundi, the Sudan, and Uganda.

Health Needs/Traditional Practices:
Many Congolese are not accustomed to visiting the doctor's office on a regular basis. Women find it embarrassing to be examined by male doctors and to discuss family planning with them. These matters are traditionally considered personal and private. It is especially difficult for parents to talk to the children about sex education. Traditionally, it is the responsibility of grand parents to discuss such issues. Since most of the grand parents are not here in the USA, this creates a vacuum that is not filled by any other family member. Since the Congolese consider children to be a great gift, they are not comfortable with the idea of family planning.

Since affordable housing is inaccessible to most Congolese newcomers, they usually share space with other family members. The resulting crowded living arrangement exposes them to several health problems.

The idea of preventive medicine and primary care is not very well recognized. Also, most members of this community are not familiar with the workings of managed care.

Mental Health:
Since traditionally, life is communal, the Congolese have a hard time adjusting to the seemingly more insular lifestyle in this country. There are quite a few emotional problems that arise in relation to this phenomenon.

The idea of seeking help for such problems is considered an intrusion of one's privacy, and also a sign of both personal and family weakness. It brings shame to discuss such matters outside

of the family. Therefore, people hesitate to access services for mental health. Yet, the problems of isolation, depression, and suicide continue to exist.

Barriers to Access:
The greatest barrier to any services that the community faces is language. In addition, lack of information about services and lack of health care coverage make it difficult for members of this community to access services.

Additional Information:

The Democratic Republic of the Congo:
Republique Democratique du Congo

Capital:	Kinshasa
Population:	50,481,305
Health	Infant mortality rate: 99.45 deaths/1,000 live births
	Life Expectancy—*Total population:* 49.44 years
	Male: 47.28 years *Female:* 51.67 years
Literacy:	*Total population:* 77.3%
	Male: 86.6% *Female:* 67.7%

Reference:

U.S Central Intelligence Agency: The World FactBook, 1999
The World Almanac and Book of Facts, 1998
Ngolela Wa Kabongo, PhD: *A Background to Baraza La Wasaidizi,* April 2000

Dominicans

Dominican Population in Massachusetts:

1990 Census: U.S. / Ancestry	1990 Census: MA / Ancestry	2000 Community Estimates
505,690	29,065	35,000

Country of Origin:
The Dominican Republic shares the Island of Hispaniola, also known as Quiskeya, with Haiti. It is approximately 700 miles Southeast of Florida, located between the islands of Cuba, Jamaica and Puerto Rico.

About half of Dominicans live in rural areas, including many that are small landholders. Haitians form the largest foreign minority group.

Migration Trends:
Dominicans began to arrive in the late 1960s and early 1970s as political refugees. Since the 1960s, services in the Dominican Republic have been breaking down because of overcrowding and, some would argue, because the government ignores or encourages emigration to Puerto Rico and the United States. During the 1980s, the Dominican Republic became the sixth largest source of legal immigration to the United States.

Geographic Locations:
Most Dominicans reside in the Boston area—Jamaica Plain, Roxbury, Hyde Park and Dorchester. Other cities with a significant Dominican population are Lynn and Lawrence.

Demographics:
Approximately 36 % of the Dominican community live below the poverty level. The median household income is $19,986.

Seventy-five percent of all Dominicans are foreign born. Fourteen percent are naturalized U.S. citizens.

Language Spoken:
Spanish.

Historical Background:
The Spanish were the first to colonize the Dominican Republic in 1492, making it a base for the exploration and colonization of the New World. The conquests of the Spanish explorers were marred, however, when in 1586, England's Sir Francis Drake and his men attacked and destroyed Santo Domingo. It would be centuries before the grand old city was fully restored. In the next century, the Spanish could no longer hold the entire island of Hispaniola and ceded what is now Haiti to France. The decades that followed were a tumultuous time of invasions by the French, Spanish, and Haitians.

The Dominican Republic finally achieved independence on February 27, 1844, under the leadership of Juan Pablo Duarte and the La Trinitaria movement. The country, however, remained in turmoil as harsh dictators ruled the people. During World War I, the United States sent in the Marine Corps and set up an administration in the country from 1916 until 1924. Following U.S. occupation, the Dominican Republic witnessed attempts at self-government and democratization. Because of repeated coups and continued unrest, the U.S. again sent the

Marines to the Dominican Republic in 1965. This time, a lasting democracy was eventually established.

Although there is now peace throughout the Dominican Republic, there remains a great deal of unemployment and poverty. Tourism has brought in some money, but the weak economy continues to rely heavily on agriculture. The Dominican Republic is the Caribbean destination with the most apparent distinction between rich and poor.

Religion:
95% are Roman Catholic.

Health Notes/Traditional Medical Traditional:
In a recent study assessing the health needs of Boston, Dominicans commonly stressed that they lacked proper access to health care. Participants also repeatedly mentioned the perceived high prevalence rates of diabetes type II, hypertension, arthritis and asthma were identified repeatedly by study participants. Other issues addressed were obesity, cancers of the cervix, pancreas, prostate and stomach, AIDS, substance abuse, smoking, intentional and occupational injury and low birth weight.

Since the 1980s, preventable infections such as tuberculosis and typhoid have increased in the Dominican Republic. Despite this alarming rise, 48% of children under the age of one are still not vaccinated.

Direct associations between lower socioeconomic statuses and poor health would seem to indicate a need for basic health care services.

High birth rates indicate high levels of need for prenatal and postnatal care.

Mental Health Needs:
Depression, anxiety, alcoholism, and alcohol-related problems are some of the mental health needs identified for Latinos in general.

Barriers to Access:
The most commonly cited barriers to accessing health services include the lack of professional interpreter services, unfamiliarity with the US health care system, the concept of prevention and primary care and lack of health insurance.

Although no reliable information is available on Dominicans, compared to the general population, Latinos are less likely to have health insurance and in turn, more likely to avoid public health facilities, hospital outpatient clinics and emergency rooms for health care.

It is important to note that of the working Latinos, 80% are currently employed in jobs that either pay extremely low wages or offer no insurance.

Additional Information:

Dominican Republic:
República Dominicana

Capital:	Santo Domingo
Population:	8,129,734
Health:	Infant mortality rate: 42.52 deaths/1000 live births
	Life expectancy—*Total population:* 70.07 years
	Male: 67.86 years *Female:* 72.4 years
Literacy:	*Total population:* 82.1%
	Male: 82% *Female:* 82.2%

References:

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Eritreans

Eritrean Population in Massachusetts:

1990 Census: U.S. / Ancestry	1990 Census: MA / Ancestry	2000 Community Estimates
N/A	N/A	2,000

Country of Origin:
Located in the horn of Africa, Eritrea is bordered by the Red Sea, Sudan, Dijoubti and Ethiopia. The country is agrarian and the economy depends on subsistence agriculture. Approximately 85 percent of the population is rural and make their living through farming and/or shepherding.

Geographic Locations:
Most Eritreans reside in the greater Boston area, including Allston/Brighton, Jamaica Plain, Cambridge, Lynn and Chelsea.

Language/s Spoken:
Eritrea contains nine ethnic groups—Tigre, Mensa, Saho, Billen, Afar, Kunama, Baria, Hedareb, and Rasiada. Each ethnic group has its own language, lives in a defined area, and is at a separate socio-economic and political level. Tigrigna is Eritrea's official language, and its speakers are the most numerous. Many Eritreans also speak Arabic.

Historical Background:
Eritrea declared its independence on May 24, 1993, after a three decade long struggle for secession from Ethiopia. Eritrean villages experienced war like conditions for the better part of the duration of the civil war. More than half a million Eritrean refugees live around the world, primarily in Sudan. Eritrea is currently at war with Ethiopia, in what is described as the bloodiest war of the decade.

Religion:
The two main religions in Eritrea are Islam and Coptic Christianity. Smaller numbers of people are Catholic, Protestant or follow animistic faiths. There are also small numbers of Jews, many of whom migrated to Israel in 1985 and 1991.

Family:
Eritreans believe children are the gift of God. Most will have as many children as they can, even if resources are scarce to support the family. Family planning is not commonly practiced. Pregnancy before marriage is traditionally unacceptable to Eritreans.

Health Needs/Traditional Medical Practices:
Within the last 30 years of armed conflict, organizations have established small hospitals and clinics that are scattered throughout the nation. Although these organizations have provided sufficient emergency care, modern medical practice remains quite underdeveloped.

Sick or hospitalized Etitreans tend to take on a passive and dependent role. Physicians are expected to know what is best for the patient. Eritrean physicians would never inform a patient of a terminal diagnosis; instead, confiding such news to a close relative. Eritreans are not comfortable taking off their clothes for physical examinations. Women especially prefer to be treated by a female health care provider and to have a female interpreter. It is very

uncomfortable for Eritrean women to answer questions about sexual activity. Also, during childbirth, most Eritrean women are not comfortable in a delivery room setting.

Eritreans have believed that illness, and the power to cure, is the work of God. Conversely, it is believed that diseases, along with natural disasters, are direct punishments from God. Some Eritreans believe that the "evil eye" can cause illnesses and even death. Another common perception is that a demon can enter the body and cause ailments until its demands are met.

Eritreans who have settled in Massachusetts need more appropriate health services and information.

Mental Health Needs:
Although there is no comprehensive study of the mental health status of Eritrean refugees, it appears that hardships experienced under repressive political systems, combined with time spent in refugee camps, have contributed to depression, anxiety, isolation and other symptoms of post-traumatic stress syndrome. Also, isolation creates severe hardship for the many single adults who have emigrated to the U.S. In addition, the sense of shame associated with mental illness is a deterrent to those seeking help.

Barriers to Access:
The most commonly cited barriers to health access include lack of professional interpreter services, unfamiliarity with the U.S. health care system, the concept of prevention and primary care, and lack of health insurance.

Additional Information:

State of Eritrea:
Hagere Ertra

Capital:	Asmara
Population:	3,984,723
Health:	Infant mortality rate: 76.84 deaths/1,000 live births
	Life expectancy—*Total population:* 55.74 years
	Male: 53.61 years *Female:* 57.95 years
Literacy:	*Total population:* 20%
	Male: N/A *Female:* N/A

References:

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"Eritrean Cultural Profile," Cross Cultural Health Care Program, Harborview Medical Center, University of Washington, Seattle, WA http://healthlinks.washington.edu/clinical/ethnomed.
Population Division and Statistics Division of the United Nations Secretariat. www.un.org/Depts/unsd/social.
U.S. Department of State. www.state.gov/www/background_notes
U.S. Central Intelligence Agency: The World FactBook

Ethiopians

Ethiopian Population in Massachusetts:

1990 Census: U.S. / Ancestry	1990 Census: MA / Ancestry	2000 Community Estimate
30,581	864	11,500

Country/Region of Origin:
Ethiopia, the largest country in East Africa, is roughly about the size of Texas, Oklahoma, and New Mexico combined. Located in the Horn of Africa, Ethiopia is bordered on the north and northeast by Eritrea, on the east by Djibouti and Somalia, on the south by Kenya, and on the west and southwest by Sudan.

Ethiopia's population is highly diverse. Although there are more than eighty different ethnic groups within Ethiopia (some of which have as few as 10,000 members), the Oromo, Amhara, and Tigrans make up more than three-fourths of the population.

Migration Trends:
Ethiopians began immigrating to the United States because of political instability and war. Resettlement of Ethiopians in the United States began in 1978, and has steadily continued to this present day. Lately, many newcomers have arrived via the Diversity Visa Lottery.

Geographic Locations:
Most Ethiopians reside in the greater Boston area, including Allston/Brighton, Dorchester, Roxbury, Jamaica Plain, Cambridge, Lynn and Chelsea. Recently, an influx of Ethiopians have settled in Randolph and Brockton as well.

Demographics:
Due to the arrival and settlement of immigrant families, the predominance of males in the community has steadily decreased.

Language/s Spoken:
There are over 80 different languages spoken in Ethiopia. Amharic and Tigrinya are the major languages spoken by most Ethiopians in the Boston area.

Historical Background:
Tracing its history back 3,000 years, Ethiopia has never been colonized. According to tradition, Menelik I founded the kingdom of Ethiopia in the 10th century B.C. The first recorded kingdom, however, is that of Aksum (Axum), founded around the 1st century A.D. by traders from Saudi Arabia. With the conquest of Islam in the 7th century, Aksum lost control of the Red Sea routes, resulting in a period of chaos. With the founding of a new Solomonic dynasty, order was restored in the 13th century. A war to expel the encroaching Somalis in 1543 was successful, but exhausted the nation, resulting in ruinous civil wars for which beset the country for the next two centuries. Finally in 1889, Menelik II, supported by Italy, instituted a strong rule. Claiming that Menelik had agreed to the establishment of a protectorate, Italy invaded Ethiopia in 1895 but was decisively defeated at Aduwa in 1896.

In 1930, after the empress died, the regent, adopting the throne name Haile Selassie, was crowned emperor. His reign was interrupted in 1936 when Italian Fascist forces invaded and occupied Ethiopia. The emperor was forced into exile in England despite his plea to the League

of Nations for intervention. Five years later, the Italians were defeated by British and Ethiopian forces, and the emperor returned to the throne.

After a period of civil unrest beginning in February 1974, army officers overthrew Haile Selassie and immediately nationalized the economy, proclaiming Ethiopia a socialist state. In 1977, Colonel Mengistu Haile Mariam brutally established himself as an authoritarian president. Under Mengistu, Ethiopia experienced serious political and economic problems; in particular, a secessionist movement in Eritrea, a rebellion in the Tigré province in the north, war with Somalia over the Ogaden, and reoccurring widespread famine. In 1991, guerrillas drove Mengistu into exile. Tigréan guerrillas subsequently captured Addis Ababa, establishing an interim government with Meles Zenawi as president. Eritrea declared its independence on May 24, 1993, and the two countries have since been at war ever since. The bloody conflict has claimed tens of thousands of lives and a solution has yet to be found. Currently, the country continues to face another cycle of widespread famine and war.

Religion:
In general, most of the Christians live in the highlands, while Muslims and adherents of traditional African religions tend to inhabit lowland regions. The percentages include 40% Muslim, 45-50% Ethiopian Orthodox Christian, 5% Protestant, with the remainder adhering to indigenous beliefs. Many Jewish Ethiopians migrated to Israel in 1985 and 1991.

Family:
In Ethiopia, family ties are considered strong. Families tend to be large (seven or eight children), and typically includes the extended family. Households in the Ethiopian community include from one to six persons, half of whom are children under age 10. The divorce rate is high and mothers have a hard time raising children as single parents. In times of crisis, the family will take full responsibility for the family member's problems, whether it being financial, health or social. A great deal of interdependence is needed to accomplish a task or solve a problem. Traditionally, disputes are settled by elders. The society respects elders and accepts their admonitions or advice. Interaction between family members is often personal, informal and intimate.

Health Needs/Traditional Medical Practices:
Refugees from urban centers in Ethiopia have experience with western-style medicine. Ethiopians from rural areas, however, have trouble understanding the concept of disease and their causes, means of transmission, and methods of prevention. They may not understand the practice of withholding treatment until diagnostic work is done. Because Ethiopians are accustomed to receiving antibiotics or other medications for every illness, they may feel it is a waste of time to go to a doctor if no medication is given, even for a minor illness.

The businesslike and direct approach of Western doctors is in contrast with the more interpersonal approach of Ethiopian doctors. This difference may contribute to the general lack of trust towards the health care system. For example, an Ethiopian doctor will never inform a patient of a terminal diagnosis. Instead, the doctor will confide such information to a close relative, who would be more capable of applying the best methods for which to positively encourage the patient.

Ethiopians often believe that illness is determined by fate. As a result, the concept of screening and preventive care is not familiar to many Ethiopians. Rural Ethiopians depend primarily on traditional healers who treat illnesses with local herbal and animal remedies. Spiritual healing, such as prayer, is also common. Rural Ethiopians who come to the city often keep their traditional beliefs and attitudes towards health.

Alcohol abuse and domestic violence is a growing problem with the Ethiopian community. Traditionally, the concept of chemical dependence as an illness is not recognized. There is a need for more resources that can be used to combat domestic violence and alcohol abuse.

Mental Health Needs:
Although there is no comprehensive study investigating the mental health status of Ethiopian refugees, it appears that hardships experienced under repressive political systems and time spent in refugee camps have contributed to depression, anxiety, isolation and other symptoms of post-traumatic stress syndrome. Unfortunately, a sense of shame masks the prevalence of mental health problems in general. Within the Ethiopian community, there is a great need to promote mental health problems as treatable illnesses.

Barriers to Access:
The most commonly cited barriers to health care access include lack of professional interpreter services, unfamiliarity with the U.S. health care system, the concept of prevention and primary care, and lack of health insurance.

A major barrier to access for Ethiopians is the lack of appropriate information. Women worry that nursing in public is inappropriate in the U.S. and also find that work or school interrupts the feeding schedule. Most are unfamiliar with pumping and storing breast milk. The cost of health care is also a problem for many Ethiopians. Those who cannot afford to pay are afraid to use the health care system. Little information is available about the Basic Health Plan or other options.

Ethiopians who come from rural areas have very limited English language skills. Although interpreters may be provided in most health care settings, the interpreters are not always appropriate. Ethiopian women prefer female doctors and interpreters, especially for OB/GYN care. Patients are not comfortable with interpreters because of gender differences (women prefer female interpreters; men prefer male interpreters). In some cases, patients are not even aware of the existence of interpreter services.

The emergence of ethnic politics in the national scene somewhat contributes to patients not trusting some interpreters whose ethnicity may be different from theirs. Consequently, patients often feel they cannot express all their needs and therefore, may not trust the medications prescribed.

Additional Information:

<u>Federal Democratic Republic of Ethiopia:</u>
Yeltyop'iya Federalawi Demokrasiyawi Ripeblik

Capital:	Addis Ababa
Population:	59,680,383
Health:	Infant mortality rate: 124.57 deaths/1,000 live births
	Life expectancy—*Total population:* 40.46 years
	Male: 39.22 years *Female:* 41.73 years
Literacy:	*Total population:* 35.5%
	Male: 45.5% *Female:* 25.3%

References:

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S. Alexander, The International Institute, Boston,MA.
U.S Central Intelligence Agency, The World FactBook

Haitians

Haitian Population in Massachusetts:

1990 Census: U.S. / Ancestry	1990 Census: MA / Ancestry	2000 Community Estimate
289,521	23,692	75,000

Country of Origin:
Haiti is approximately 700 miles southeast of Florida, located between the islands of Cuba, Jamaica and Puerto Rico. Roughly the size of Maryland, Haiti shares a Caribbean island with the Dominican Republic. The original inhabitants, the Taino/Arawak Indians, named the island Quiskeya. The modern appellation is derived from the word *ayti* or *hayti,* meaning "mountainous" in the indigenous Taino/Arawak Indian language. Haiti's climate is generally tropical. Once covered with virgin forests, it is currently in a state of environmental devastation due to deforestation and soil erosion.

Haiti is densely populated, with approximately 250 people per square kilometer (650 per sq. mi.). Approximately 95% of the Haitians are of African descent, with the rest being mostly a mix of African-Caucasian ancestry. A few are of European or Levantine stock.

Migration Trends:
Most Haitians living in Massachusetts have immigrated over the past three decades.

Following the September 1991 military coup that ousted President Jean-Bertrand Aristide, large numbers of Haitians fled their country. A limited number of these Haitian individuals were admitted to the United States with refugee status. The remainder has been granted parole status. These "parolees" must undertake the complex and lengthy legal process of filing political asylum claims in order to be eligible to remain in the U.S.

The political situation in Haiti has had a negative affect upon its economy. Inflation continues to be high. Haitians who had repatriated after Operation Restore Democracy – the U.S. backed military operation which returned President Aristide to Haiti in October of 1994 – are now finding their way back to the United States, seeking economic opportunities.

Geographic Locations:
The largest Haitian communities in the United States are in Miami, New York City, Boston and Chicago.

Haitians in Massachusetts reside primarily in Dorchester, Mattapan, and Roxbury. A significant number have settled in Cambridge and Somerville, with a growing population being found in Allston, Brockton, Framingham, Hyde Park, Jamaica Plain, Medford, Randolph, Springfield, Waltham, Watertown and Worcester.

Demographics:
The first wave of Haitians who migrated to the Boston area were generally from a small educated and professional group intent on pursuing higher education. In the 1980's, however, political repression and economic deprivation in Haiti have forced both urbanites and rural dwellers to leave the island.
The Haitian population in Massachusetts is composed primarily of young adult males. There are, however, a growing number of large families with young children.

Language/s Spoken:
French is one of two official languages, but it is spoken by only about 10% of the people. All Haitians speak Creole, the country's other official language. English is increasingly spoken among the young and in the business sector.

Haitian Creole / Kreyòl is spoken by the entire population. The term "creole" is derived from the Portuguese word *crioulo*, meaning a person of European ancestry born and raised abroad. Creole arises when languages come in contact with one another and is directly related to pidgin. Pidgin is the simplification of a base language, with contributions from a native language, used to fulfill special, temporary, communication needs. When a pidgin becomes the language of an individual, and subsequently a community, a creole language evolves. Other creole languages include Afrikaans (Dutch-based), Neo-Melanesian (English-based) and Chamorro (Spanish-based).

Some say krèyol is derived from an Afro-Portuguese pidgin used by sailors, slaves and slave traders that came in contact with the 17th Century French of settlers. Others say it is derived from a pidgin spoken by Portuguese and French sailors in the 15th and 16th Centuries.

Historical Background:
In the 16th Century, after almost entirely eliminating the resident Taino/Arawak Indians, the Spaniards forcefully imported West Africans to a Caribbean island that they named Santo Domingo. Spain eventually relinquished the western part of the island to France in 1697. France, calling it Saint Domingue, turned it into one of its richest colonies, at the expense of over half a million slaves.

Nota Bene: The name *Hispaniola,* or "little Spain," is the Spanish language reference to the island. Haitians sometimes use the appellation *Quiskeya* to refer to the island.

Boukman, Georges Bissou and Toussaint Louverture initiated a slave rebellion in 1791. By 1794, the Spanish and British troops were thoroughly defeated, granting Louverture command of the entire island. In 1802, Napoleonic forces captured Louverture and took him to France, where he eventually died in prison. The remaining forces joined together and Napoleon, who was already exhausted in Europe, conceded to the Haitian rebellion.

In 1804, Haiti declared independence, becoming the second independent nation in the west and the first free black republic in the world. The new leaders, keen in military organization, established what would become a tradition of military rule in Haiti. The majority peasant population remained outside the formal political, educational and economic structure. This pattern stills exists in Haiti.

In 1915, following intervention policies influenced by the Monroe Doctrine, the United States landed in Haiti, declared martial law, and proceeded to reorganize the entire government. After 20 years of occupation—achieving relative political stability and moderate improvements to Haiti's infrastructure—the U.S. withdrew. Given the absence of firmly established political and social institutions, however, the military remained the only cohesive institution in the country, and the tool by which future governments would rule.

François Duvalier ("Papa Doc" – referring to his medical background) was elected president in 1957. He immediately established a dictatorship by changing the constitution, replacing an independent military with a presidential guard and creating a rural militia (*tontons macoutes).* Duvalier's regime was marked with terror, corruption and extremes of poverty and wealth. He named his son, Jean-Claude Duvalier ("Baby Doc"), as his successor.

A grass-roots movement grew into a great resistance, eventually ending the thirty-year dictatorship of the Duvalier family. Beginning in 1986, Haiti was ruled by a series of provisional governments. In 1987, a constitution was adopted that provides for an elected bicameral parliament, an elected president who serves as head of state, a prime minister, cabinet of ministers, and supreme court appointed by the president with Parliament's consent.

In December of 1990, Jean-Bertrand Aristide, a charismatic Roman Catholic priest, won 67% of the vote in a presidential election that international observers deemed largely free and fair. Aristide took office in February 1991, but was overthrown and forced into exile by dissatisfied elements of the army. In 1994, a United States negotiating team persuaded the military leadership to step down and Aristide was restored to the presidency.

In the 1995 elections, René Preval, a former Prime Minister in Aristide's administration, was elected president. Although conditions in Haiti continue to remain somewhat volatile, recent democratic advances have indicated that stability is slowly beginning to return to the island nation.

Religion:
Most of the population adheres to Roman Catholicism. Haitians, however, tend to see no conflict with voodoo traditions of African origin co-existing with Christian faiths. Vodou may be considered Haiti's national religion. The word *vodou, or vodun,* comes from the Fon language of Benin in West Africa and means "spirit." Voodoo is derived from a synthesis of African religious beliefs based on family spirits who generally are called on to help and protect. Some of the spirits are ancestors of the living, while others represent human emotions and forces of nature. The spirits are either inherited or bought. During and after colonial times, there was a great effort to Christianize Africans. Africans, however, did not give up their spiritual identity. Roman Catholic symbols and prayers, ceremonies and altars, in blending with Vodou rituals and traditions, make for a religion that is uniquely Haitian.

Health Needs:
Access to doctors, nurses and health centers as typically understood among U.S. practitioners is not widely available in Haiti, and Haitians immigrants may have experienced a widely divergent range of allopathic health care. Eighty percent of Haitians live in rural areas, where there are very few physicians (1 per 13,000 persons). The majorities of rural Haitians, as well as the urban poor, usually seek a medical doctor only if they are seriously ill. For immediate care, many rely on prayer, home remedies, or a variety of lay healers including herbalists, lay midwives, faith healers and vodou practitioners. Thus, health seeking behavior may vary widely within the Haitian population, depending in the onset of an illness, the proximity of services, level of education, and the patient's health beliefs, as well as those of family and friends.

In general, Haitians may divide diseases into two categories: Naturally caused diseases, for which allopathic medicine is thought to be effective, and non-natural diseases, thought to be caused by supernatural causes. Illnesses which are believed to have natural explanations are considered amenable to treatment by home remedies. This has a number of major implications for American practitioners. Firstly, the health provider should expect that many Haitian patients have tried home remedies prior to presentation or used medications prescribed for friends or relatives with similar symptoms, and should inquire about these in each history. There is a strong oral tradition within each family and communtiy that teach folk remedies, including Bush Teas, laxatives, enemas, massage with oil mixtures, warm leave baths, soaks and dietary changes.

Secondly, the patient will most likely expect the physician to prescribe medication to treat a naturally caused illness; an injection is thought to be most effective. Whatever intervention is thus instituted, it is of critical importance to educate the patient with respect to the typical

disease course of their illness. This discussion should include the reasons that medications are not prescribed or effective, if this is the case.

Thirdly, the physician should try to determine the patient's beliefs concerning the cause of the illness for which he or she is presenting. Often, a patient states a diagnosis upon presentation and request treatment for it. It is important, especially in cases where rapid diagnoses are not forthcoming, for the health care provider to work carefully to explain what is and is not known about possible causes for the patient's symptoms. Furthermore, many Haitians are unaccustomed to hearing from medical professionals that a diagnosis cannot be quickly established, especially in cases where the medical evaluation has included blood tests and other sophisticated procedures. When this occurs, suspicion that a non-natural explanation for the illness may be raised. It is thus important for the physician who acknowledges that an etiology is uncertain to demonstrate his or her competence by clearly explaining subsequent steps to be taken in investigating the illness.

Non-natural diseases, or supernatural illness, are thought to be caused by a curse sent by an enemy or the action of one of the *loa* (spirits of the ancestors who serve as a conduit between humans and the gods). These diseases are thought to occur in two categories: illness of hyperacute onset that affect apparently healthy individuals, such as stroke, or sudden infant death syndrome; and illnesses of protracted course and/or poor outcome such as HIV disease, tuberculosis, cancer or mental illness. Non-natural illnesses are not considered to be the province of medical doctors, and any chance for cure is thought to lie in intervention on the part of a vodou priest or priestess (*hungan* or *mambo*) or through faith healing.

When Haitians immigrate to the United States, they bring with them the disease paradigm of their home community, as well as its set of responses to the onset of illness. Haitians with a higher level of education are likely to present earlier in the course of an illness, and will be more comfortable within the American health care setting. Others, if home remedies have not produced a positive outcome, may first consult someone in the family or friends with a more extensive knowledge of herbal remedies. These failing, s/he may then consult an herb doctor, a hungan, mambo, or a medical doctor. The choice of the practitioner is likely to depend on the patient's understanding of the causality of the illness.

> --Nicole Prudent M.D., MPH and Michele David, MD, MBA, MPH
> *Health Beliefs and Approaches to Care in Haitian Immigrant Communities in the United States.*

Mental Health Needs:
Many Haitians suffer from post-traumatic stress disorder, severe anxiety and suicidal feelings due to direct and secondary acts of extreme violence in their country.

Upon arrival in the United States, family breakdowns often occur, often leaving women and children isolated.

Barriers to Access:
The most commonly cited barriers to accessing health services include the lack of professional interpreter services, unfamiliarity with the U.S. health care system, the concept of prevention and primary care and lack of health insurance. In Haiti, health care services are paid for up front. The system of health insurance in the U.S. is difficult to understand and often prohibitively expensive.

Many Haitians without documented status may avoid public facilities, including hospitals and health centers, due to the fear of being deported. Also, many Haitians have long working hours, which leave them with little time to seek medical help.

The language Haitians may use to describe an illness might not translate directly to American definitions, resulting in diagnosis problems. For example, a Haitian might use the term "stomach ache," to describe a pain in the thorax region.

Additional Information:

Haiti:
Ayiti

Capital:	Port-au-Prince
Population:	6,884,264
Health:	Infant mortality rate: 97.64 deaths/1000 live births
	Life expectancy—*Total population:* 51.65 years
	Male: 49.53 years *Female:* 53.88 years
Literacy:	*Total population:* 45%
	Male: 48% *Female:* 42.2%

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Indians

Indian Population in Massachusetts:

1990 Census: U.S. / Ancestry	1990 Census: MA / Ancestry	2000 Community Estimates
815,447	19,719	N/A

Country of Origin:
India is the largest country in South Asia, occupying most of the subcontinent. Found between the Bay of Bengal and the Arabian Sea, India borders Pakistan, Nepal, China, Bangladesh, Bhutan and Myanmar.

Although India occupies only 2.4% of the worlds land area, it supports over 15% of its population. Only China has a larger population. Almost 40% of Indians are younger than 15 years of age. About 70% of the people live in more than 550,000 villages, and the remainder in more than 200 towns and cities.

The caste system reflects Indian occupational and religiously defined hierarchies. Traditionally, there are four broad categories of castes (varnas), including a category of outcastes, earlier called "untouchables" but now commonly referred to as "dalits." Within these broad categories there are thousands of castes and subcastes, whose relative status varies from region to region. Despite economic modernization and laws countering discrimination against the lower end of the class structure, the caste system remains an important source of social identification for most Hindus and a potent factor in the political life of the country.

Migration Trends:
Indians began to arrive in the United States in the nineteenth century. Consisting of mostly Punjabi Sikhs who settled in Northwestern United States and Canada, they first found employment in lumberyards, steamship companies, in agriculture and railroad construction. Once in America, this group faced difficult resistance, especially from organized labor who successfully lobbied Congress to pass a law barring Asian immigration. In 1946, this ban was eventually lifted to allow a hundred immigrants enter the country every year. The 1966 Immigration Act eventually nullified immigration laws that were discriminate towards those of Asian decent.

According to the U.S. Census Bureau, in 1990 there were 815,447 Indian Americans living in the United States. This represents a 125% increase over the 1980 Census figures. Indians make up 11.2% of the Asian American population, making them the fourth largest Asian group in the U.S., after the Chinese, Filipino, and the Japanese (although Census projections indicate that the Indian American population may have already surpassed the Japanese American community). Of the 815,447 Indian Americans, 450,406 were born in India.

Geographic Locations:
Massachusetts is home to the ninth largest Indian population in the United States. Most members of the community live in Boston, Cambridge, Somerville, Framingham, Waltham, Worcester, Brookline, Newton, Amherst, and Springfield.

Demographics:
There is a concern that the larger than average median family income observed among the Indian population in Massachusetts could mask its existing poverty. Community sources are quick to point to the rising levels of poverty among Indians; particularly among female-headed households and the elderly.

Language/s Spoken:
India has eighteen official languages, combined with numerous dialects spoken all over the country. The major languages are English, Hindi, Bengali, Telugu, Marathi, Tamil, Urdu, Gujarati, Malayalam, Kannada, Oriya, Punjabi, Kashmiri, Sindhi, Sanskrit, and Hindustani. Most Indians in Massachusetts speak English, Hindi, Bengali, Gujarati, Urdu, or Punjabi.

Historical Background:
Civilization in India goes back to 1500 BC, when Aryan tribes migrated to merge with the earlier tribes and settle in the area. Between the 8th and the 12th centuries, Arab invaders and Turkish Muslims had infiltrated the region and introduced Islam. Between the 15th and the 17th centuries, the Portuguese, Dutch and the British were engaged in trading in the area. Eventually, the British East India Company served as the conduit through which the British gained control of most of the country. India subsequently fell under the political rule of the British Parliament.

Beginning in 1920, Indian leader Mohandas K. Gandhi transformed the Indian National Congress political party into a mass movement to campaign against British colonial rule. The party used both parliamentary and nonviolent resistance and non-cooperation to achieve independence. India became a democratic republic in 1950.

In response to a movement desiring a separate Muslim nation, Britain partitioned Pakistan into a separate state. Relations between India and Pakistan have been tense and spotted with military confrontations ever since. India's boundary with China is also a point of contention, as is a dispute with Bangladesh over boundary that has yet to be defined. Moreover, India suffers from strife caused by several regional and religious militant groups desiring separation, autonomy and supremacy.

Religion:
Although 83% of the people are Hindu, India also is the home of more than 120 million Muslims—one of the world's largest Muslim populations. The population also includes Christians, Sikhs, Jains, Buddhists, and Parsis.

Although mostly Hindu, the Massachusetts Indian population consists of those who represent all the faiths listed above.

Health Needs/Traditional Medical Practices:
Service providers state that high blood pressure and coronary artery disease is a major problem within the Indian population. Diabetes has also been found to exist at an alarmingly high rate. It is common practice to cook with ghee (clarified butter), which is high in saturated fats and therefore linked to cardiovascular diseases.

It is important to note that India is a large country with major linguistic and cultural differences among populations. Therefore, it may not be appropriate to discuss a uniform traditional belief system or cultural pattern. Traditional healing is used a lot, and may even be the preferred method of care. Indian patients feel more comfortable with same sex health care providers and interpreters.

Mental Health Needs:
Mental health is a taboo topic among the Indians mainly due to the misunderstanding that mental illness is the same as "insanity." Mental health is often not openly talked about because many consider it to be a personal issue.

Many new immigrants encounter mental health issues relating to the immigration process, including culture shock, adjustment issues, role reversals, and intergenerational and marital conflicts.

Barriers to Access:
The most commonly cited barriers to accessing health services include the lack of professional interpreter services, unfamiliarity with the U.S. health care system, the concept of prevention and primary care and lack of health insurance.

Additional Information:

India

Capital:	New Delhi
Population:	1,000,848,550
Health:	Infant mortality rate: 60.81 deaths/1000 live births
	Life expectancy at birth—*Total population:* 63.4 years
	Male: 62.54 years *Female:* 64.28 years
Literacy:	*Total population:* 52%
	Male: 65.5% *Female:* 37.7%

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Koreans

Korean Population in Massachusetts:

1990 Census: U.S. / Ancestry	1990 Census: MA / Ancestry	2000 Community Estimate
836,987	12,878	25,000

Country of Origin:
Located between China and Japan, Korea is a mountainous peninsula approximately 500 miles long. At present, the land is divided by a demilitarized zone between the Republic of Korea (South Korea) and North Korea.

The origins of the Korean people are obscure. Korea was first populated by a people or peoples who migrated to the peninsula from the northwestern regions of Asia, some of whom also settled parts of northeast China (Manchuria). Koreans are racially and linguistically homogeneous, with no sizable indigenous minorities, except for some Chinese (approximately 20,000). With 46 million people, South Korea has one of the world's highest population densities—much higher, for example, than India or Japan—while the territorially larger North Korea has only about 22 million people. Ethnic Koreans now residing in other countries live mostly in China (1.9 million), the United States (1.52 million*), Japan (681,000), and the countries of the former Soviet Union (450,000).

* 2000 estimates.

Migration Trends:
Prompted by poor economic, political and social conditions in their homeland, Koreans began to immigrate to the U.S. as early as 1885. Although these numbers were initially very small, the first notable migration took place in 1905, when approximately 7,000 contract laborers worked in the pineapple and sugar cane fields of Hawaii. With the outbreak of the Korean War, the first major flow of Koreans started to arrive. During this time, political dissidents, students, so-called "war brides" and Korean children adopted by American families poured into the United States.

After 1967, new immigration policies allowed not only students and professionals to immigrate, but Korean families as well. It was these families which comprised the bulk of Koreans – first generation Korean Americans – living in the U.S.

Geographic Locations:
The Korean community tends to reside in small pockets around the state. The largest groupings can be found in Lexington, Acton, Andover, Cambridge, Brookline, Somerville, Leominster, and around the former Fort Devens area.

Language/s Spoken:
Korean is a Ural-Altaic language and is related to Japanese and remotely related to Hungarian, Finnish, Estonian, and Mongolian. Although dialects exist, the Korean spoken throughout the peninsula is mutually comprehensible. In North Korea, the Korea alphabet (hangul) is used exclusively, unlike in South Korea, where a combination of hangul and Chinese characters is used as the written language. English is now widely taught in high school.

Historical Background:
Like that of many ancient cultures, Korea's earliest history is based largely on mythic legend. It is believed to have started in 2333 B.C., when *Tan-gun*, a semi-deitic figure, unified the various

primitive tribes of southern Manchuria and northern Korea into a single kingdom which came to be known as *Chosun* – "Land of the Morning Calm." Ancient Chosun lasted for over a thousand years, but gave way to the era known as Three Kingdoms (*Shilla, Koguryo and Paekche*). The struggle among these three powers for supremacy over the entire peninsula went on for about 700 years until Shilla, in alliance with China, overtook the others and ruled as the Unified Shilla Dynasty from 668-935 A.D. Its rich, Buddhist influenced, culture flourished for two and a half centuries before giving away to the Koryo Dynasty (918-1392), which adopted Confucianism as its governing ideology. The country, however, never gave up Buddhism. Arts and crafts made great strides during this period, particularly the Koryo celadon ceramic. Korea's last dynasty was the Chosun, also known as the Yi Dynasty (1392-1910). This period witnessed remarkable scientific and cultural achievements, including the invention of Korea's native script, Hangul. The nation suffered Japanese incursions and the dynasty came to an end with the imposition of Japanese colonial rule from 1910-1945.

Independence was restored in 1945 after the defeat of the Japanese in World War II. Although Koreans found themselves liberated from almost 40 years Japanese domination, they also had to face the tragic division of land across the 38th parallel. As a result, the Republic of Korea was established south of the line of division, and the United Nations officially recognized the government as the only legitimate and sovereign government in Korea. The tragedy of a divided land and people did not end. The communist north, with the support of the Soviet Union, attacked the Republic of Korea in 1950 and launched the Korean War. After 3 years of costly fighting, the war ended in a truce along the 155 mile Demilitarized Zone (DMZ), at approximately the 38th parallel, where it had begun. This division still stands, to the grief of many Koreans; particularly those with separated families.

Religion:
Korea's traditional religions are Buddhism and Shamanism. Buddhism has lost some influence over the years, but is still followed by about 27% of the population. Shamanism—traditional spirit worship—is still practiced. Confucianism remains a dominant cultural influence.

Christian missionaries arrived in Korea as early as the 16th century, but it was not until the 19th century that they founded schools, hospitals, and other modern institutions throughout the country. Christianity is now one of Korea's largest religions. In 1993, nearly 10.5 million Koreans, or 24% of the population, were Christians (about 76% of them Protestant)—the largest figure for any East Asian country except the Philippines.

Although religious groups exist in North Korea, most available evidence suggests that the government severely restricts religious activity.

In Massachusetts, many Korean-Americans rely on Korean Christian churches (Catholic and Protestant) to provide their religious and cultural/social life.

Family:
Family ties are very strong and home life has been based on the teachings of Confucious. Filial piety to parents and ancestors, fidelity to spouse, and respect to the elders continue to be vital family values. Obedience and courtesy are accorded the utmost importance. In traditional Korean society, mothers would stay home and take responsibility for raising the children. Grandparents often live under the same roof and play an important role in guiding young children to learn and carry on family traditions.

Health Needs/Traditional Medical Practices:
Korean doctors practice the oriental theory of health, which is based on harmony between yin and yang (positive and negative energy). They also see the importance of balancing the five elements (wood, fire, earth, metal and water) in order to understand one's illness. Korean oriental medicine attaches importance not only on the body, but also the situation and condition in which the body is placed. Oriental medicine usually includes natural products such as herbs, including roots and barks, as well as minerals. Treatment also includes acupuncture, moxibution and cupping therapies.

In order to address some of the health needs faced by this population in Massachusetts, the Coalition for Healthy Korean Americans (COHKA) was founded in 1998. Its mission is to promote the health of Korean Americans through education and preventive health services, and provide access to culturally competent health care, hereby allowing appropriate utilization of the system. To meet this end, the Koh Memorial Health Center (KHC) was established in Stoneham, Massachusetts.

Mental Health Needs:
Like many other immigrants, Koreans may face difficulty adjusting to a new culture and language. Families, in particular, often experience intergenerational conflict as the rapid assimilation of children runs counter to the more traditional values of their parents and grandparents. The stress of acculturation and familial conflict may lead to domestic violence and/or substance abuse. Sub-populations at risk may include women, elderly, students (particularly those here alone without family or other support), and second generation Koreans (who are struggling with identity issues).

Barriers to Access:
Most recent Korean immigrants do not have adequate command of the English language that would allow for effective communication with their providers. The most commonly cited barriers to accessing health services include the lack of professional interpreter services, and unfamiliarity with the U.S. health care system. Even Koreans who speak English prefer Korean providers. Many Koreans work for small businesses that cannot provide health care coverage for their employees. Koreans are commonly not familiar with managed care and employer-based coverage.

Many Korean Americans lack knowledge regarding the importance of prevention and primary care. A significant number have not had a physical examination in several years. There are women who have never had a pap smear or mammogram even though their ages are appropriate for these screening tests.

Additional Information:

South Korea:
Taehan Min'guk

Capital:	Seoul
Population:	46,884,800
Health:	Infant mortality rate: 7.57 deaths/1,000 live births
	Life expectancy—*Total population:* 74.3 years
	Male: 70.75 years *Female:* 78.32 years
Literacy:	*Total population:* 98%
	Male: 99.33% *Female:* 96.7%

North Korea:
Choson Minjujuuni Inmin Konghwaguk

Capital:	PyongYang
Population:	21,386,109
Health:	Infant mortality rate: 25.52 deaths/1,000 live births
	Life expectancy at birth—*Total population:* 70.07 years
	Male: 67.41 years *Female:* 72.86 years
Literacy:	*Total population:* 99%
	Male: 99% *Female:* 99%

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Portuguese

Portuguese Population in Massachusetts:

1990 Census: U.S. / Ancestry	1990 Census: MA / Ancestry	2000 Community Estimate
1,153,351	289,424	530,000

* For more information on Portuguese speakers, see the chapters on the Brazilian and Cape Verdean communities.

Countries/Regions of Origin:
Portugal is located in the southwest extreme of Europe, on the Iberian Peninsula. It shares borders with Spain and faces the Atlantic Ocean. The people are mostly of homogeneous Mediterranean stock, with citizens of black African descent, numbering less than 100,000, who immigrated to mainland during de-colonization.

Please Note: Portuguese speakers from former Portuguese colonies include those arriving from Guinea-Bissau, Angola, Mozambique and Macao.

Azores: The Azores, with a population of 236,000, is located 760 miles west of Lisbon and 2,110 miles from New York. The name comes from the Portuguese word for goshawk, birds, which are native to the islands. The archipelago is formed by a group of nine islands of volcanic origin. The central group of islands consists of Terceira, Graciosa, Sao Jorge, Pico and Faial. To the east are the islands of Sao Miguel and Santa Maria and to the west Flores and Corvo. The Azores have a privileged climate, maritime and mild, because of the influence of the Gulf Stream. There are no great variations in temperature. A 1951 agreement gave the US rights to use defense facilities in the Azores.

Madeira: Madeira, consisting of the islands of Madeira and Porto Santo, has a population of 253,000. It is located 350 miles off the northwest coast of Africa. The name Madeira means timber, referring to the extensive forests that used to cover the islands. It is also known for its Madeira wine. Both the Azores and Madeira archipelagos were offered partial autonomy in 1976.

Macao: Macao, with a population of 367,000, is an area of six square miles consisting of an enclave, a peninsula and two small islands located at the mouth of the Pearl River near Canton, China. Portugal granted broad autonomy to Macao in 1976. In 1987, Portugal and China agreed that Macao would revert to China in 1999. Macao, like Hong Kong, was guaranteed 50 years of non-interference in its way of life and capitalist system.

Migration Trends:
The largest Portuguese-speaking groups came from Portugal and the Azores and are now well into the second and third generations in Massachusetts.

The first Portuguese explorer to settle in New England was Miguel Corte-Real, from the island of Terceira in the Azores. After his ship was wrecked off the coast, he settled in Fall River in 1511, and established himself as chief of the Wampanoag Indians. Other Portuguese explorers soon followed his lead. Expeditions settled in California in the mid-16th century, followed by the Portuguese Jews arriving in Manhattan in 1654, and the Portuguese from the Azores reaching Hawaii in 1810.

U.S. fishing and whaling boats would often stop in Portuguese waters, providing many Portuguese with access to the United States. In addition, American schooners routinely called on the Azores for cargo, particularly oranges. In the 19th century, Portuguese and Azorean men used to work their way across the Atlantic on these boats. After the middle of the century, their families began to follow; many of whom settled in New England.

In 1957, preceded by violent earthquakes, the Capelinhos volcano off the island of Faial in the Azores erupted. The volcano remained active for five years, completely burying a number of towns on the island. In 1960, responding to the urgent appeal for immigration privileges, President Kennedy granted 2,000 visas to the residents of Faial. The US Congress later granted an additional 1,500 visas.

Military service in Portugal is compulsory. In 1960, war broke out in the Portuguese colonies of Angola, Mozambique and Guinea Bissau. Military forces were to spend over thirteen years engaged in armed conflict with the colonies. Many young people fled Portugal in order to avoid a war in which they did not believe in.

Geographic Locations:
Portuguese from mainland Portugal, Madeira and the Azores can be found in Boston, Cambridge, Somerville, Peabody, Lowell, Hudson, Taunton, Fall River, Ludlow and New Bedford.

Demographics:
The Portuguese and Azorean populations are largely older adults.

Language/s Spoken:
Portuguese.

Historical Background:
Portugal is composed of continental Portugal on the Iberian Peninsula, and the archipelagos of Azores, Madeira and Macao. It has been an independent state since the 12th century and a monarchy until a revolution in 1910 established a republic and forced King Manuel I to flee. In 1932, Portugal was lead by a repressive government headed by Premier Anatonio Oliveira Salazar. Illness forced him to retire in September 1968.

On April 25, 1974, the government was seized by a military junta lead by General António de Spínola, who was subsequently named president. This event ended an era that lasted 50 years known as the "Salazarista" era. Since 1976, Portugal has been a parliamentary democracy. The new government eventually granted independence to the former Portuguese colonies of Guinea-Bissau, Mozambique, Cape Verde Islands, Angola, Sao Tomé and Príncipe.

Religion:
Portugal is traditionally a strong Roman Catholic country, with affiliation being about 97% of the population.

Health Notes/Traditional Medical Practices:
Common health problems in the Portuguese community are heart disease, high blood pressure, alcoholism and depression.

Individuals from the south of Portugal may be carriers of sickle cell disease. Because patients are Caucasians, the diagnoses are sometimes missed.
Portuguese women have been known to suffer from *agonias*, described as chest palpitations, shortness of breath and a general feeling of anxiety. Patients often want to be prescribed medications in order to validate their illness or the seeking of medical help.

Follow up with medication is often interrupted as soon as symptoms fade. Also, patients may interrupt their medication if they are concerned that it will interfere with any alcohol that might be consumed with dinner, or as part of an occasion.

Mental Health Needs:
Due to the hardships of emigration and adaptation to the United States, depression and anxiety are common health problems within the Portuguese community.

Barriers to Access:
The most commonly cited barriers to accessing health services include the lack of professional interpreter services, unfamiliarity with the US health care system, the concept of prevention and primary care and lack of health insurance.

Additional Information:

Portuguese Republic:
Republica Portuguesa

Capital:	Lisbon
Population:	9,9918,040
Health:	Infant mortality rate: 6.73 deaths/1000 live births
	Life expectancy—*Total population:* 75.88 years
	Male: 72.51 years *Female:* 79.46 years
Literacy:	*Total population:* 85%
	Male: 89% *Female:* 82%

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Somalis

Somali Population in Massachusetts:

1990 Census: U.S. / Ancestry	1990 Census: MA / Ancestry	2000 Community Estimate
N/A	N/A	5,000

* 1990 Census do not list figures for Somalis.

Country/Region of Origin:
Somalia is a long, narrow country that wraps around the Horn of East Africa It is bordered by Kenya to the south, Ethiopia to the west, Djibouti to the northwest, the Gulf of Aden in the north and Indian Ocean to the east. It is slightly smaller than Texas. The climate in Somalia is consistently hot and dry, except at the higher elevations in the north. There are two rainy seasons; droughts occur every 2/3 years in one season, and every 8-10 years in the other.

Somalis have a remarkably homogeneous culture and identity. As early as the seventh century A.D., indigenous Cushitic peoples began to mingle with Arab and Persian traders who had settled along the coast. Interaction over the centuries led to the emergence of a Somali culture bound by common traditions, a single language, and the Islamic faith.

Today, about 60% of all Somalis are nomadic or semi-nomadic pastoralists who raise cattle, camels, sheep, and goats. About 25% of the population are settled farmers who live mainly in the fertile agricultural zone between the Juba and Shebelle Rivers in southern Somalia.

Sizable ethnic groups in the country include some 35,000 Arabs, about 2,000 Italians, and 1,000 Indians and Pakistanis.

Migration Trends:
Due to political instability, drought and famine in their home country, Somalis began immigrating to the US in the early 1980s. In 1991, to escape the ravages of a civil war, these numbers increased tremendously. Between 1992 and 1999, approximately 1,200 Somalis arrived in Massachusetts as refugees.

Prior to their arrival in the US, many Somali refugees spent lengthy periods of time in refugee camps in Kenya. Living conditions and medical care in the camps were poor, and safety was never assured.

Somalis are currently experiencing a second migration, moving from state to state within the US. This has to do with the influence of their nomadic heritage, as well as the desire to reunite family or clan groups.

Geographic Locations:
Somalis in the U.S. live predominantly in San Diego, Seattle, Metropolitan Washington DC and Minneapolis. Most Somalis who have immigrated to Massachusetts live in the greater Boston area-including Roxbury, Mission Hill, Dorchester, Cambridge, Somerville, East Boston, Charlestown, Quincy, Lynn, Chelsea, and Revere.

Demographics:
Arrivals to Massachusetts are young: One-third is under the age of 15 and nearly half are between the ages of 15 and 34.

Languages Spoken:
The Somali language is an Afro-Asiatic language closely related to Oromiffa and more distantly to the Semitic languages Arabic, Hebrew and Amharic. A uniform orthography was not adopted until 1973. Since the vast majority of the population is Muslim, Arabic may be understood. Older Somalis from the north speak English and those from the south speak Italian.

Facility with speech is highly valued in Somali society. Pride is also important, and the ability to use language to save face is essential. Humor, based on puns and word play, is used to blunt criticism and to extricate oneself from embarrassing situations.

Historical Background:
Colonial rule divided the Somalis from the mid-1800's until 1960, when rapid progress toward self-government was being made in British Somaliland. Elections for the Legislative Assembly were held in February 1960, and one of the first acts of the new legislature was to request that the United Kingdom grant the area independence so that it could be united with Italian Somaliland when the latter became independent. The protectorate became independent on June 26, 1960; 5 days later, on July 1, it joined Italian Somaliland to form the Somali Republic. In June 1961, Somalia adopted its first national constitution in a countrywide referendum, which provided for a democratic state with a parliamentary form of government based on European models.

By 1990, little remained of the Somali Republic. The army dissolved into competing armed groups loyal to former commanders or to clan-tribal leaders. The economy was in shambles, and hundreds of thousands of Somalis fled their homes. In 1991, Siad Barre and forces loyal to him fled the capital; he died in exile in Nigeria. In 1992, responding to the political chaos and death in Somalia, the United States and other nations launched Operation Restore Hope. Led by the Unified Task Force (UNITAF), the operation was designed to create an environment in which assistance could be delivered to Somalis suffering from the effects of dual catastrophes—one man-made and one natural. UNITAF was followed by the United Nations Operation in Somalia. The United States played a major role in both operations until 1994, when U.S. forces withdrew after a pitched gun battle with Somali gunmen that left hundreds dead or wounded.

In the midst of such devastation, civilians have suffered from rampant violence, famine and starvation. Over one million people have fled to refugee camps in neighboring countries. Resettlement programs have allowed families to move to Europe and the US.

Religion:
Almost all Somalis are Sunni Muslim. Attitudes, social customs and gender roles are based primarily on Islamic tradition. During the month-long religious holiday of Ramadan, people pray, fast and refrain from eating, drinking and smoking during the day. Pregnant women, children, sick and senile persons are exempt from this practice. Many religious holidays include the ritual killing of a goat or lamb. Muslim tradition forbids eating pork or drinking alcohol. Some women cover their bodies and head.

Family:
Family and social structure in Somalia is by clan and sub-clan. Since Somalis are largely nomadic, it is common for several subclans to live inter-mixed in one area. Membership in a clan is determined by paternal lineage or by marriage into the clan. Men who can afford to do so, may have up to four families. Family planning has little cultural relevance; traditionally, a woman's status is enhanced by the number of children she bears.

Health Notes/Traditional Medical Practices:
Sickness is usually discussed when a person is seriously ill and requires advice. Western hospitals register the most common illnesses as diarrhea, fever (usually representing malaria) and vomiting. Families almost always receive antibiotics at the hospital, and so set a precedent for expecting to receive medicine, even for a cold. Oral rehydration therapy is common and familiar. Families are usually aware of colds, asthma and ear infections. Parasitic illnesses are relatively common.

Overseas medical screenings and initial health assessments of 259 refugees from Somalia, who arrived between 1997 and 1999, have documented the need for primary care follow-up. Some of the findings include 50% positive tuberculin skin tests, 60% positive for parasitic diseases, 48% needing dental follow-up, 8% positive for hepatitis B and 100% with incomplete immunizations. Twenty-eight percent were anemic, with higher rates among children under 2 years of age.

It is considered to be uncaring to tell a terminally ill person or their family that the person is dying. It is acceptable, however, to describe the extreme seriousness of an illness. Often, when death is impending, a special portion of the Koran is read at the patient's bedside.

Some believe that sickness stems from the "evil eye" and supernatural beings. A person can give someone else the evil eye on purpose, or inadvertently by praising that person, which brings harm or illness to the person praised. Somali mothers may be uncomfortable when a doctor tells them that their babies are big and healthy, for fear that the evil eye will cause harm to the child.

Both males and females in Somalia are traditionally circumcised before the age of five. Circumcision is commonly viewed as a rite of passage and necessary for marriage. Uncircumcised people may be viewed as unclean. A traditional doctor, a medical doctor or a nurse in a hospital usually performs male circumcision. Female circumcision is available in some hospitals, but is usually performed by female family members. The most common procedure in Somalia for female circumcision is "infibulation," involving the removal and suturing of most of the genital tissue, leaving a posterior opening. This is an important and sensitive issue for Somali women. There are no known cases of female circumcision in the U.S.

Traditional healers are specialized, and sought for particular sicknesses. Religion also plays a large role in healing. Traditional medical practices include fire-burning, herbal remedies, casting and prayer. Fire burning is a procedure where a stick from a special tree is heated until it glows and is then applied to the skin in order to cure the illness. It is commonly used for hepatitis, where the heated stick is applied once to each wrist and 4 times to the abdomen. It is also used for malnutrition; when the head seems to be large, out of proportion the body, the heated stick is applied to the head in order to reduce the head size. Pneumonia is treated with fire burning, herbs and sometimes percuntaneous removal of fluid from the chest. Seizures are treated with herbs and readings from the Koran. Stomachaches and backaches are treated with herbs, while rashes and sore throats are treated with a tea.

Mental Health Needs:
Welfare Reform legislation, inadequate mental health resources and war-related trauma, including anxiety, depression and post-traumatic stress disorder, create compounded hardships upon Somalis immigrating to the U.S. Within the Somali community, there is a noticeable increase in homelessness, depression and other debilitating mental health disorders. As traditional family support systems are not always available, linguistically and culturally appropriate mental health services are urgently needed.

There is a need for information detailing laws and resources that can be used to combat domestic violence.

Barriers to Access:
Somali refugees and immigrants need more information and education about health care and services. The most commonly cited barrier to accessing health services is difficulty with the English language and the lack of professional interpreter services. There is also a great unfamiliarity with the health care system in Massachusetts and with the idea of prevention as primary care. Lack of health insurance is a great obstacle to those seeking services, as is the alienation experienced in the health care settings where traditional family and medicinal practices are not recognized.

The hospital experience is new to Somalis who are not from urban areas. Negative connotations of the Western hospital experience include the drawing of blood and leaving a hospital visit without a prescription. Leaving without medicine might imply that the hospital staff is unfamiliar with tropical diseases such as malaria.

Most Somalis are not comfortable receiving care from a member of another gender, and prefer same sex providers. Discussing sex related issues are taboo in Somali culture.
During Ramadan (see *Religion*), patients will take medications only at night, when food and liquids may be consumed.

Additional Information:

Somalia:
Soomaaliya

Capital:	Mogadishu
Population:	7,140,643
Health:	Infant mortality rate: 125.77 deaths/1,000 live births
	Life expectancy—*Total population:* 46.23 years
	Male: 44.66 years *Female:* 47.85 years
Literacy:	*Total population:* 24%
	Male: 36% *Female:* 14%

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Southeast Asians

Southeast Asian Population in Massachusetts:

Country of Origin	1990 Census: U.S. / Ancestry	1990 Census: MA / Ancestry	2000 Community Estimates
Cambodia	134,955	11,821	38,000
Laos	146,930	3,953	8,000
Vietnam	535,825	13,101	45,000
Total:	817,710	28,875	91,000

Since the late 1980s, the predominant Southeast Asian new arrival population has been Vietnamese. As a result, the Vietnamese comprise the largest Southeast Asian subgroup in Massachusetts.

Countries of Origin:
The three countries under French colonial rule, Cambodia, Laos and Vietnam, formed French Indochina from the later part of the 19th century until the end of World War II.

Cambodia: Cambodia shares borders in the north with Laos and Thailand, in the east with Vietnam and in the southwest with the Gulf of Thailand. The landscape comprises tropical rainforest and fertile cultivated land traversed by many rivers. In the northeast area rise highlands. Ninety percent of the population is Cambodian; Chinese and Vietnamese comprise 5% of the population each.

Laos: Laos' population was estimated at about 5.2 million in 1997, dispersed unevenly across the country. Most people live in valleys of the Mekong River and its tributaries. Vientiane prefecture, the capital and largest city, had about 489,000 residents as of 1992. The country's population density is 21.5/sq. km. About half the country's people are ethnic Lao, the principal lowland inhabitants and politically and culturally dominant group. The Lao are descended from the Tai people who began migrating southward from China in the first millennium A.D. Mountain tribes of Sino-Tibetan (Hmong, Yao, Akha, and Lahu) and Tai ethno-linguistic heritage are found in northern Laos. Collectively, they are known as Lao Sung or highland Lao. In the central and southern mountains, Mon-Khmer tribes, known as Lao Theung or midland Lao, predominate. Some Vietnamese and Chinese minorities remain, particularly in the towns, but many left in two waves, after independence in the late 1940s and again after 1975.

Vietnam: Ethnic Vietnamese constitute almost 90% of the population. Originating in what is now southern China and northern Vietnam, the Vietnamese people pushed southward over several centuries to occupy the entire eastern seacoast of the Indochinese Peninsula. This expansion began in 939 AD, after a millennium of Chinese occupation. Although Vietnamese culture was strongly influenced by traditional Chinese civilization, the struggle for political independence from China instilled a strong sense of national identity in the Vietnamese people. Nearly 100 years of French rule (1858-1954) introduced important European elements, but the Vietnamese still attach great importance to the family and continue to observe rites honoring their ancestors, indicating the persistence of tradition.

Migration Trends:
Before 1975, there were very few Southeast Asians living in the United States. The fall of South Vietnam, however, created a flood of refugees who feared political reprisals from the incoming governments. From 1975 to 1977, refugees exited the three Indochinese countries in droves. In 1978, unrelenting famine and political repression pushed a vast number of refugees over the borders of Thailand and onto the seas in small, overcrowded boats. Hundreds of thousands of Vietnamese, Laotians, Hmong, Kmhmu, and overseas Chinese literally piled up on the shores of Malaysia and Indonesia, or amassed desperately into prison-like camps along the Thai border.

Southeast Asian refugees began to resettle in the United States in 1975, peaking in 1975 and 1979-1981. The first wave were mostly South Vietnamese evacuated after the fall of Saigon. The second wave (1979-1981) were more heterogeneous in nationality and ethnicity, including Cambodians fleeing the Khmer Rouge; Laotians, Hmong, Kmhmu from Laos; Vietnamese and ethnic Chinese from the three Indochinese countries.

After Congress passes the Amerasian Homecoming Act in 1987, there was an increase in the number of Vietnamese Amerasian arrivals. Amerasians are the sons and daughters of American fathers and Vietnamese mothers, born during the Vietnam War. Springfield and Boston were designated resettlement "cluster sites." The majority of Amerasians were arriving with their mothers and other family members, but some arrived as unaccompanied minors.

Since 1990, Vietnamese political detainees have been arriving in the United States. They are former army officers and civil servants of the South Vietnamese government, who collaborated with the American administration and armed forces during the Vietnam War. After the Communist victory in 1975, they were detained for many years in Communist "re-education centers" which were, in fact, labor camps.

The McCain amendment to the Foreign Operations Appropriation bill for FY'97 required interviews to determine the refugee status of unmarried children over 21 years of age of those persons who were approved as refugees under the political detainees program after April 1, 1995.

Resettlement Opportunity for Vietnamese Returnees (ROVR) — On January 23, 1997, the governments of the United States and Vietnam agreed, via an exchange of letters, on the modalities of a resettlement opportunity for certain Vietnamese who are of special interest to the U.S. and who have returned to Vietnam from first-asylum camps in Japan, Hong Kong and Southeast Asia under the Comprehensive Plan of Action for Indochinese Refugees. This opportunity applied only to those who returned to Vietnam on or after October 1, 1995, and who were otherwise eligible for consideration. The processing and interviews were supposed to be concluded by the end of 1998.

Geographic Locations:
Southeast Asians have settled in all regions of Massachusetts. The primary locations are listed below:

Cambodian communities: Chelsea, Revere, Lynn, Lowell, Lawrence, Attleboro/Fall River, Fitchburg, Holden, Hudson, Leominster, Shrewsbury, Worcester, Springfield, Amherst/Northampton and Boston (Allston/Brighton, East Boston).

Laotian communities: Boston, Lynn, Lowell, Brockton, Fitchburg/Leominster, Holden, Hudson, Shrewsbury, Southbridge, and Worcester; Hmong in Brighton, Fitchburg/Leominster and Brockton; Kmhmu mainly in Boston, Lynn, and Southbridge.

Vietnamese communities: Boston (Dorchester, Brighton, East Boston), Chelsea, Everett, Malden, Somerville, Quincy, Lowell, Lawrence, Methuen, Brockton, Fitchburg, Holden, Hudson, Leominster, Worcester, Springfield and Amherst/Northampton. The Amerasians can be found mainly in Springfield and Boston.

Demographics:
When the Southeast Asian first began to arrive in Massachusetts, 50 percent were under the age of 18, 15 percent under age six, and only 5 percent over age 65. The population is now growing older, and the number of elderly is increasing.

About 55 percent of the population are males and 45 percent are females, with more males in the Vietnamese community and larger numbers of widows heading households in the Cambodian community.

Within the Vietnamese community, there are, as mentioned, two subgroups of recent arrivals—Amerasians and political detainees. Born between 1950-1975, the Amerasians had limited opportunities and faced frequent discrimination in Vietnam. According to a Boston survey, 85 percent of Amerasian respondents had less than six years of education, and 32 percent had less than three years. The political detainees, who are now 45 to 70 years old, live mostly in greater Boston, Lowell, Worcester and Springfield.

Many Southeast Asians came from rural areas in their native country with limited educational opportunities and skills training.

According to a Refugee Mental Health Needs Assessment, English proficiency levels among Southeast Asians were low: only 15.5 percent of Vietnamese clients and 5.3 percent of Cambodian clients spoke English "very well." There is now a young generation of Southeast Asians who have been going to schools in the U.S., and who have no problems with English. The older generation, however, is still struggling with language barriers and cultural differences.

Language/s Spoken:
Cambodian: Khmer (official) spoken by more than 95% of the population, including minorities; some French still spoken; English increasingly popular as a second language.

Laotian: The official and dominant language is Lao, a tonal language of the Tai linguistic group. Midland and highland Lao speak an assortment of tribal languages. French, once common in government and commerce, has declined in usage, while knowledge of English –the language of the Association of Southeast Asian Nations (ASEAN) –has increased in recent years.

Vietnamese: Vietnamese, English (increasingly favored as a second language), some French, Chinese and Khmer, mountain area languages.

Religions:
Aside from a minority of Christians, most Southeast Asians are predominately Buddhist. The branch of Buddhism followed by the Cambodians and the Laotians is Theravada Buddhism, whereas the Vietnamese are mostly Mahayana Buddhists. Both schools teach that one should follow the moral eight-fold path and cultivate a detachment from striving and desire, since all things are impermanent and unhappiness results from attachment to worldly things. The distinction is that Theravada Buddhism emphasizes *merit*—the accumulation of good deeds which allows the individual to be reborn into a better situation and to avoid ill fortune. Mahayana Buddhism puts less emphasis on merit and more on a philosophically correct life to bring peace and contentment. (*Zen* belongs to Mahayana Buddhism and not to the Theravada School).

The belief in spirits is still strong among Southeast Asians, especially among the Hmong population. Since spirits are believed to be ubiquitous, the animistic Hmong emphasize the importance of harmony with all things. Next to the headman, the shaman is the most important individual in the society. Healthcare providers working with the Hmong group should read the book *The Spirit Catches You and You Fall Down,* by Anne Fadiman, for examples of how medicine can sometimes tragically clash with traditional belief systems.

Health Needs:
There is a major need among Southeast Asians to access appropriate health services and information in Massachusetts.

Certain communicable diseases are more common in Southeast Asia than in the U.S. Refugees from Southeast Asia, including Amerasians and political detainees in Vietnam, have lived under generally very poor conditions and had little access to health services. This population is at increased risk for infection and disease, including:

Tuberculosis - Southeast Asians are less than one percent the Massachusetts population but accounted for almost 15 percent of all new TB cases in 1994.

Hepatitis B - Approximately 12 percent of Southeast Asians are infected with hepatitis B virus. Viral infection can lead to liver cancer, cirrhosis, and premature death. The Massachusetts Department of Public Health's Hepatitis B Prevention Project and the Refugee and Immigrant Health Program are successfully preventing new prenatal infections.

Parasitic infections - Untreated parasitic infections can lead to failure to thrive, anemia, and in the case of some infections, gall bladder disease or death.

Traumatic pasts, separation from families, stresses of acculturation, lack of traditional supports and the easy availability of both drugs and alcohol in this country have contributed to the development of alcohol and drug abuse among Southeast Asians. While rates of substance abuse are thought to be no higher than for general U.S. population, there are no culturally appropriate substance abuse treatment services for Southeast Asians. In April of 1997, a small pilot project called Project Sangkhim (Hope I Khmer), designed to help Cambodian clients, started operating at the Revere Counseling Center to be closed down in October of 1999, due to lack of funding.

Because Southeast Asians are generally a young population, there is an increased need for maternal and child health services. Currently, adequate prenatal care for Cambodians is the poorest of any ethnic group in the state.

Mental Health Needs:
Southeast Asian refugees have experienced a disproportionate amount of severe psychological trauma as a result of their experience with war and political repression. In the Refugee Mental Health Needs Assessment conducted by the Massachusetts Department of Mental Health, 60 % of Cambodian and 48 % of Vietnamese respondents reported being robbed, raped or tortured during their escape from their native country. Ninety-five % of Cambodians reported having suffered the loss of family members or relatives in an unnatural manner.

In a California Department of Mental Health Study, "severe" mental health service needs were identified as four times greater among Southeast Asian refugees. About 15 % of the Southeast Asians had symptoms of severe mental health problems, compared to three % of the general population.

Almost 83 % of Cambodian refugees in the Massachusetts study reported feeling depressed, with more than half experiencing sleep and eating disorders and severe anxiety.

Sleep and eating disorders were also reported by 75 % of Vietnamese refugees in the Massachusetts study. Moreover, almost 60 % reported they were not able to access appropriate mental health services for help.

The Refugee Mental Health Needs Assessment also identified Vietnamese veterans, especially those who were political detainees, and Amerasians as being more at risk for developing mental health problems than the general Vietnamese population.

After the fall of Saigon in Vietnam in 1975, political detainees suffered many years of physical and mental torture in "re-education camps," separation from families, loss of legal status to hold jobs or to own property, and malnutrition. Despite their desires to rebuild their lives, regain their self-esteem, and for some, reunite with their families, the wide variety of stresses they have experienced over time have made transition and adjustment of life in the United States difficult.

Domestic violence is a growing problem in Southeast Asian communities. The causes are mainly two-fold:
1. Role reversal in families where many men can no longer fulfill the traditional requirements of the husband's and father's role,
2. The loss of the extended family support system in which conflicts could be resolved peacefully.

Intergenerational conflict is also a growing problem as children raised in a new country move away from the values and understandings of their parents. This situation combined with the fact that able-bodied refugees usually work on many jobs explains the terrible isolation of the elderly group who already have more problems than the rest of the family with language barriers and cultural differences.

Note: These two issues are common to all newcomer communities. They are mentioned here as they seem to be more acute within the Southeast Asian groups.

Barriers to Access:
The most common cited barrier to accessing health services is difficulty with the English language and the lack of professional interpreter services. There is also a great unfamiliarity with the health care system in Massachusetts and with the idea of prevention as primary care. Lack of health insurance is a great obstacle to seeking services, as is the alienation experienced in the health care settings where traditional family and medicinal practices are not recognized.

Additional Information:

Kingdom of Cambodia:
Preahreacheanachakr Kampuchea

Capital:	Phnom Penh
Population:	11,626,520
Health:	Infant mortality rate: 105.06 deaths/1000 live births
	Life Expectancy—*Total population:* 48.24 years
	Male: 46.81 years *Female:* 49.75 years
Literacy:	*Total population:* 35%
	Male: 48% *Female:* 22%

Lao Democratic Republic:
Sathalanalat Paxathipatai Paxaxon Lao

Capital:	Vientiane
Population:	5,407,453
Health:	Infant mortality rate: 89.32 deaths/1000 live births
	Life expectancy—*Total population:* 54.21 years
	Male: 52.63 years *Female:* 55.87 years
Literacy:	*Total population:* 60%
	Male: 70% *Female:* 48%

Socialist Republic of Vietnam:
Cong Hoa Xa Hoi Chu Nghia Viet Nam

Capital:	Hanoi
Population:	77,311,210
Health:	Infant mortality rate: 34.84 deaths/1,000 live births
	Life expectancy—*Total population:* 68.1 years
	Male: 65.71 years *Female:* 70.64 years
Literacy:	*Total population:* 93.7%
	Male: 96.5% *Female:* 91.2%

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Former Soviet Union Citizens

Former Soviet Union Citizen Population in Massachusetts:

Country of Origin	1990 Census: U.S. / Ancestry	1990 Census: MA / Ancestry	2000 Community Estimate
Belorussian	4,277	99	N/A
Estonian	26,718	977	N/A
Latvian	100,331	6,479	N/A
Lithuanian	811,865	68,447	N/A
Russian	2,952,987	133,080	N/A
Ukranian	740,803	17,500	N/A
Total:	4,644,710	227,095	72,000

Country/Regions of Origin:
The Former Soviet Union was comprised of Latvia, Lithuania, Estonia, Kyrgyztan, Kazakstan, Georgia, Azerbaijan, Russia, Ukraine, Bellorusse, Turkmenistan, Uzbekistan, Tadjikistan.

Migration Trends:
In 1987, as travel restrictions were lifted on persons persecuted for religious beliefs in the USSR, Massachusetts began to see a dramatic increase in the number of refugees arriving in the state. Nearly 20,000 refugees fleeing religious persecution and ethnic hostilities, had immediately resettled in Massachusetts. When the Soviet Union dissolved, the number increased dramatically. The refugee population has changed from the Russian speaking Jewish immigrants to Evangelical and Pentecostal Christians who have been resettling in the western part of the state.

Geographic Locations:
Most of the state's Russian-speaking Jewish population lives in the greater Boston area: particularly in the Allston/Brighton and Brookline/Newton areas. Growing communities are found in Framingham, Lynn, Salem, Swampscott, and Worcester. The Westfield/Springfield area is a major resettlement area for Evangelical Christians. People are increasingly moving to Massachusetts from New York, in search of jobs.

Demographics:
The male to female ratio is approximately one to one. Compared to other refugee groups, persons from the former Soviet Union, as a whole, are an older population with approximately 35 percent between 25-44 years old and another 26 percent over age 44. The Evangelical Christian refugees generally have large families with many children.

There are two distinct groups of former Soviet Union citizens in Massachusetts: Russian-speaking Jews and Slavic Evangelicals. Russian-speaking Jews are the majority, comprising about 90 percent of the state's former Soviet Union population.

Many of the Jewish arrivals are from urban areas in the former Soviet Union, with the majority highly educated and professionally trained. Among 1994 arrivals, the largest cohort is persons age 60 and older.

Slavic Evangelicals are mostly from the rural areas of Ukraine and Siberia. Many have secondary school education with skills training in commercial driving, construction, plumbing, machinery and electrical systems.

Having very little trust for govemment, many individuals from these countries are more comfortable with employment in the private sector.

Language/s Spoken:
Soviet Jewish refugees are Russian-speaking. Most also speak the languages of the republics where they used to live (Ukrainian, Belorussian, Latvian or Uzbek, for example). Their native languages, Yiddish and Ladino, were forbidden in the Soviet Union and were spoken only at home or with close friends.

The Ukrainian language began to be differentiated from other Slavic languages, Russian in particular, as far back as the 12th century. Over time, it has borrowed and absorbed from Polish, Hungarian, German and Romanian languages.

Historical and Political Background:
The Union of Soviet Socialist Republics (USSR) was established in 1922 and dissolved in 1991. Upon dissolution, eleven of the fifteen constituent or union republics joined the Commonwealth of Independent States (CIS), while four did not. Armenia, Azerbaijan, Belarus, Kazakhstan, Kyrgyzstan, Moldova, Russia, Tajikistan, Turkmenistan, Ukraine and Uzbekistan united to form CIS, while Estonia, Georgia, Latvia, and Lithuania, chose to remain independent. The primary duties of the CIS were understood to be the prevention of inter-republican warfare, the mediation of disputes over the disposition of the former Soviet Union's military forces and the promotion of trade.

Most refugees come from either Russia or the Ukraine. Ukraine, the second largest country in Europe, is a highly developed industrial country, which has been experiencing severe economic crisis since its independence. A continuing fuel shortage and poor harvests have led to widespread undernourishment. In addition, the country is still suffering the health effects and environmental contamination from the 1986 explosion at the Chernobyl nuclear power station.

Religion:
In the United States, it has become common for new Jewish arrivals to revive religious traditions. Jewish refugees have accepted Reform Judaism as the most characteristic form of Judaism in the United States.

The main religion in Ukraine is the Eastern Orthodox (Christian) faith. Although both were persecuted, Pentecostal and Ukrainian Baptist churches have remained active in western Ukraine.

Health Notes/Traditional Medical Practices:
There is a serious need among former Soviet Union arrivals for access to appropriate health services and information. These include prenatal care, reproductive care, infant care, nutrition, family planning, geriatric care, and health education on such topics as mammograms.

Overseas medical screenings and initial health assessments of 2,228 refugees from the former Soviet Union who arrived in 1997 and 1998 have documented the need for primary care follow-up for chronic disease including hypertension, coronary disease, gastro-intestinal problems, and diabetes. Other health indicators show that 45% were tuberculin skin test positive, 43% needed dental follow-up, 3% were positive for hepatitis B and 81% had incomplete immunizations. Twelve percent were anemic, with higher rates among children under 2 years of age.

Following the collapse of the Soviet Union, health conditions in Russia and other former Soviet republics have deteriorated rapidly. The incidence of tuberculosis is six to seven times higher than in the U.S., suggesting that recent arrivals are at higher risk for infection and active

disease. Some acute infectious diseases, such as diphtheria, have reached epidemic proportions, resulting in the pronouncement of an international public health emergency by the World Health Organization.

Mental Health Needs:
Resettlement is a stressful process. Personal losses connected with resettlement may result in severe depression. These losses may include a decline in status due to skills and/or credentials which are not transferable from one country to another (it would not be uncommon to see a former nuclear physicist, for example, currently employed as a taxi driver). In this population, mental health problems are being manifested in increased health complaints, marital and intergenerational problems, often commencing soon after arrival. These problems may increase as former Soviet Union refugees are joining family members who are themselves, recent arrivals.

In the former Soviet Union, any deviation from normal mental health was considered a purely medical problem and treated by a psychiatrist on an in-patient or outpatient basis. Social services such as individual or group therapy, family counseling or services for the elderly did not exist until very recently.

The Soviet government frequently used psychiatric hospitals to incarcerate political prisoners and dissidents. This included people who continued to exercise their religious beliefs despite governmental proscriptions. There was a distrust of anyone in authority and a great reluctance to release any information that might be used against them in the future. For these reasons, the idea of obtaining professional help for emotional problems is foreign to this population, creating a natural resistance to social services in general and mental health services in particular.

Barriers to Access:
The most commonly cited barriers to health access include lack of professional interpreter services, unfamiliarity with the U.S. health care system, the concept of prevention and primary care, and the lack of health insurance.

Additional Information:

Russian Federation:
Rossiyskaya Rederatsiya

Capital:	Moscow
Population:	146,393,569
Health:	Infant mortality rate--23 deaths/1,000 live births
	Life expectancy—*Total population:* 65.12 years
	Male: 58.83 years *Female:* 71.72 years
Literacy:	*Total population:* 98%

Republic of Belarus:
Respublika Byelarus

Capital:	Minsk
Population:	10,408,523
Health:	Infant mortality rate—14.39 deaths/1,000 live births
	Life expectancy—*Total population:* 68.13 years
	Male: 62.04 years *Female:* 74.52 years
Literacy:	*Total population:* 98%

Republic of Estonia:
Eesti Vabariik

Capital: Tallinn
Population: 1,408,523
Health: Infant mortality rate—13.83 deaths/1,000 live births
Life expectancy—*Total population*: 68.65 years
Male: 62.61 years *Female:* 75 years
Literacy: *Total population:* 100%

Republic of Latvia:
Republic of Latvia

Capital: Riga
Population: 2,353,874
Health: Infant mortality rate—17.19 deaths/1000 live births
Life expectancy—*Total population:* 67.3 years
Male: 61.24 years *Female*: 73.66 years
Literacy: *Total population:* 100%

Republic of Lithuania:
Lietuvos Respublika

Capital: Vilnius
Population: 3,584,966
Health: Infant mortality rate—14.71deaths/1000 live births
Life expectancy—*Total population:* 68.96 years
Male: 62.91 years *Female:* 75.31 years
Literacy: *Total population:* 98%

Ukraine:
Ukrayina

Capital: Kiev
Population: 49,811,174
Health: Infant mortality rate—21.73 deaths/1000 live births
Life expectancy—*Total population:* 65.91
Male: 60.23 *Female:* 71.87
Literacy: *Total population:* 98%

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www.un.org/depts/unsd/social
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U.S. Department of State, Central Intelligence Agency; The World Factbook, 1999
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http://healthlinks.washington.edu/clinical/ethnomed.

Tibetans

Tibetan Population in Massachusetts:

1990 Census: U.S. / Ancestry	1990 Census: MA / Ancestry	2000 Community Estimate
N/A*	N/A*	300

* 1990 Census do not list figures for Tibetans.

Country/Region of Origin:
With an area of 2.5 million square kilometers, Tibet lies at the center of Asia Tibet, located to the west of mainland China, north and east of India and Pakistan, and north of Nepal, Bhutan and Burma. The earth's highest mountains, a vast arid plateau and great river valleys make up the physical homeland of 6 million Tibetans. It has an average altitude of 13,000 feet above sea level.

The United States recognizes all of Tibet to be part of the People's Republic of China.

Migration Trends:
Over the past 30 years, less than 500 Tibetans have been able to establish residency in the United States. Poverty, travel restrictions and lack of status in the U.S. have been major prohibiting factors.

The first significant numbers of settlers arrived in the 1960's and 70's. A number of Tibetans came to the U.S. as translators, students and religious teachers. They later changed their status to permanent residents and were subsequently joined by family members.

In October of 1990, Congress passed the 1990 Immigration Act (H.R.4300), containing the provisions under Section 134 of Public Law 101-649, allowing 1,000 Tibetans to immigrate to the U.S.

There are approximately 4,000 Tibetans currently residing in the United States.

In 1992, a group of 85 Tibetans arrived in Boston. The visas issued to these individuals required that family members wait 3 years before joining them. Since 1995, there has been a flow of arrivals reuniting with their families in the United States.

Geographic Locations:
The largest populations of Tibetans can be found in the Pioneer Valley and Boston area.

Demographics:
The Tibetan population in Massachusetts is composed primarily of young adults. Lately, however, there have been a growing number of Tibetan families with young children, including children born in the U.S., settling in the area. Many Tibetans have a low level of English proficiency, and approximately half of the new arrivals have less than a high school education.

Language(s) Spoken:
Although Chinese is the official language, Tibetans converse using Tibetan (of the Tibeto-Burmese language family). Besides English, many Tibetans in Massachusetts know Hindi and Nepali; acquired during their asylum in India and Nepal.

Historical Background:
Tibet was one of the mightiest powers of Asia for centuries after it was first unified under King Song Tsen Gampo in the 7th Century AD. It was during this period that Buddhism first reached Tibet. Around the 10th Century, the last Tibetan Empire collapsed and the country began a long period of isolation.

In the 13th Century, as Genghis Kahn expanded his empire, Tibetan leaders of the powerful Sakya School of Tibetan Buddhism concluded an agreement with the Mongol rulers in order to avoid the conquest of Tibet. The Tibetan lama promised political loyalty and religious blessings and teachings in exchange for patronage and protection. The religious relationship became so important that when, decades later, Kublai Khan conquered China and established the Yuan Dynasty (1279-1368), he invited the Sakya Lama to become the Imperial Preceptor and supreme pontiff of his empire.

In 1642, the Great 5th Dalai Lama assumed both spiritual and temporal authority over Tibet with the help of a Mongol patron. The system of rule developed by the Great 5th Dalai Lama became what is the present system of Tibetan government, known as Ganden Phodrang. During the Qing Dynasty (1644-1911) close religious ties developed between the Manchu emperors and the Dalai Lama. The Dalai Lama agreed to become the spiritual guide of the Manchu Emperor, and accepted patronage and protection in exchange. The Dalai Lama maintained this "priest-patron" relationship (known in Tibetan as Choe-Yoen) with some Mongol princes as well.

Note: Lamaism is so named after its priestly upholders, the lamas, or "superior ones". In effect, it came to mean rule by a religious hierarchy headed by the Dalai Lama. Both the Dalai and Panchen Lamas, Tibetans believe, are reincarnations of different aspects of Buddha himself, the Panchen being concerned exclusively with spiritual matters while the Dalai is additionally entrusted with the nation's sovereignty.

In 1904, the British briefly invaded Lhasa and concluded a bilateral treaty, the Lhasa Convention. Following the 1911 revolution in China and the overthrow of the Manchu Empire, Tibet reasserted its independence by expelling Chinese and Manchu troops stationed in Lhasa and elsewhere. In 1914, the Treaty of Simla, concluded between Tibet and British India, also declared Tibetan independence.

In 1949 and 1950, the army of the People's Republic of China, while formally urging Tibet to join the Republic as an historical minority of the Chinese nation, claimed the Tibetan regions of Kham and Amdo, and named the remainder of Tibet an Autonomous Region of the Republic. Regional National Autonomy is the constitutional policy adopted by the Communist Party of China for integrating all regions of the People's Republic of China. Minority nationalities under state leadership practice regional autonomy in areas where they live.

In 1959, and again in the late 1980's, resistance to the Chinese military presence in Tibet resulted in violent suppression of Tibetan society. Over 1.2 million Tibetans have died since the conflict began, almost 50 years ago. There are over 130,000 Tibetans living outside of Tibet. Approximately 4,000 Tibetans reside in the US.

Religion:
Tibetan national life is dedicated to Buddhism. A very small group of Tibetans follow the Moslem faith. Tibetan culture was transformed over the thousand-year period from King Song Tsen Gampo (early 7th Century) to the Great Fifth Dalai Lama (early 17th Century) from a normally ethnocentric, imperialistic culture to a spiritual, peaceful one. A theocratic civilization evolved which was founded on the idea of the interdependence of humanity and nature. The key message in the Tibetan sect of Buddhism is to practice compassion and loving-kindness.

Bon was Tibet's indigenous religion. In one form, it was a priestly religion, intended to serve the Tibetan Kings. It was also practiced as a shamanistic religion, protecting rural communities through rituals involving Tantrism. Tantrism is a mystical form of Buddhism derived from a convergence of Buddhist and Hindu ideas. Tibetan Tantric adepts believe that with ritual and initiation into arcane realms, they can accelerate the path to enlightenment and Buddhahood to within one lifetime; all beings and things existing as an expression of the divine. Nestorian Christianity, then extant in Central Asia, also found its way into Tibetan Buddhist culture. During the reign of King Song Tsen Gampo, a minister was sent to India to learn Sanskrit and writing. A Tibetan script was modeled after Sanskrit. Indian scholars and Tibetan translators translated Buddhist literature into Tibetan text. Tibetan Buddhism experienced a golden period and dark period. The most vigorous Buddhism revival brought the great Indian master Atisha to Tibet. Atisha wrote *A lamp on the Path to Enlightenment*, which established the pattern for Lamrim, the graded path texts found in the Tibetan Buddhist tradition.

The influence of different masters led to a diversity in teachings. The four schools of Tibetan Buddhism are Kagyu, Nyingma, Sakya and Gelug. Kagyu refers to "Oral Lineage". Nyingma refers to the "Ancient Ones"; this is the oldest school of Tibetan Buddhism. Sakya refers to the "Gray Earth". Gelug refers to "The Way of Virtue"; it combines the teachings and practices of Nyingma, Kagyu and Sakya with the Sutra and Tantra systems of Indian Buddhism and the intellectual heritage of Nagarjuna and Asanga.

The cornerstone of Tibetan Buddhism is the tantric path, which involves following the Lamrim (literally, stages of the path). This practice blends the sutra teachings (based on morality, concentration, wisdom; not identifying with the personal ego) and techniques adapted from Hindu systems of yoga and tantra. The basic human passions of desire and aversion are transformed from primal urges into wholesome and helpful forces for the purpose of spiritual development.

Health Needs:
Tibetan medicine has long been highly respected throughout Asia and is still greatly valued by the Tibetan people. Its origins lie in the first traditions of the Indian ayurvedic, classical Chinese, ancient Greek, Persian and indigenous Tibetan medical healing practices. These were integrated, throughout time, by the concept of mind and body as taught in Buddhist philosophy. Tibetan medicines, mostly made from herbs and minerals, and according to natural principles, have no side effects. The medical tradition, formerly taught in monasteries, is an integral part of Tibetan culture. Many current diseases are treated with these herbal formulas, making their complementary use possible with allopathic Western medical modalities.

Tibetans come from a high plateau region, hosting the highest mountain peaks in the world. Many of those arriving in the US have gone through an asylum and settlement process in India or Nepal. The transition has subjected many to dysentery, tuberculosis, malaria and other diseases that often stem from poverty.

Hypertension, diabetes, tuberculosis and ulcers are common in the Tibetan community in Massachusetts.

Mental Health Needs:
Due to violence suffered in their country, family and culture separation anxiety, the physical and psychological stress of emigration, or adaptation to severe climate and dietary changes, some Tibetan may suffer from depression.

Religion, combined with the extraordinary amount of focus dedicated to preserving their culture and one-day perhaps returning to it, has kept members of the Tibetan community in fairly stable mental health. Due to perpetual community gatherings, religious holidays and other cultural events, The Tibetans in and around Boston have managed to maintain a close-knit community. The mental and emotional support that their network provides has helped many to endure the past atrocities committed against them.

The Tibetan Community Assistance Project, Boston, Inc. and The Tibetan Refugee Health Care Project, Alternative Resources Unlimited, Inc. II in Seekonk, are medical resources that are available to providers assisting Tibetans in need.

Barriers to Access:
The most common cited barrier to accessing health services is difficulty with the English language and the lack of professional interpreter services. There is also a great unfamiliarity with the health care system in Massachusetts and with the idea of prevention as primary care. Lack of health insurance is a great obstacle to those seeking services, as is the alienation experienced in the health care settings where traditional family and medicinal practices are not recognized.

Additional Information:

Tibet:

Capital: Lhasa
Population: 6 million Tibetans.
7.5 million Chinese
Literacy: 30%

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Newcomer Agencies & Mutual Assistance Associations (MAA's)

Mr. Chheub Heng Cambodian Community of Massachusetts (*) 191 N Common Street, 3rd Floor Lynn, MA 01905 (781) 593-4333	**Mr. Chau Ming Lee** Asian American Civic Association 90 Tyler Street Boston, MA 02111 (617) 426-9492
Mr. Samkhann Khoeun Cambodian Mutual Assistance Association * 165 Jackson Street, Lowell, MA 01852 (978) 454-4286	**Ms. Sylvia Saavedra-Keber** Concilio Hispano 105 Windsor Street Cambridge, MA 02139 (617) 661-9406
Mr. Ratha Yem Cambodian American League of Lowell 60 Middlesex Street Lowell, MA 01852 (978) 454-3707	**Mr. Juan Vega** Centro Latino 267 Broadway Chelsea, MA 02150 (617) 884-3238
Mr. Sam Som Cambodian American Assn. of Western Mass. (*) c/o Bangs Community Center 70 Boltwood Amherst, MA 01002 (413) 253-0696	**Ms. Maria-Helena Leitona** Centro Presente 54 Essex Street Cambridge, MA 02139 (617) 497-9080
Mr. Sambath Rim Cambodian Community of Greater Fall River (*) Angkor Plaza – 418 Quequechin Street Fall River, MA 02723 (508) 676-8225	**Ms. Robin Lee** Coalition For Healthy Korean Americans 41 Montvale Avenue, Suite 450 Stoneham, MA 02180 (781) 438-6886
Mr. Binyam Tamene Ethiopian Mutual Assistance Assoc. of Mass. (*) 552 Massachusetts Avenue, Suite 209 Cambridge, MA 02139 (617) 492-4232	**Mr. Duy Pham** Vietnamese American Civic Association (*) 1452 Dorchester Avenue, 3rd Floor Dorchester, MA 02122 (617) 288-7344
Ms. Mekdese Habtewold Ethiopian Community Volunteer Groups 280-300 A Street Boston, MA 02119 (617) 261-9957	**Mr. The Viet Cai** Vietnamese American Civic Association (*) 433 Belmont Avenue Springfield, MA 01108 (413) 733-9373
Ms. Lena Deevey Irish Immigration Center 18 Tremont Street, Suite 143 Boston, MA 02108 (617) 367-1126	**Mr. Long Nguyen** Viet-AID 1452 Dorchester Avenue, 3rd Floor Dorchester, MA 02122 (617) 822-3717

Ms. Maria Brito Cape Verdian Association of Brockton 575 North Montelo Street Brockton, MA 02403 (508) 559-0056	**Rev. Vumbi Johnson** (Congolese) Baraza la Wasaidizi, Inc. P.O. Box 190915 Roxbury, MA 02119 (617) 265-7057
Mr. Pierre Imbert Haitian Multi-Service Center 12 Bicknell Street Dorchester, MA 02121 (617) 436-2848	**Mr. Fausto da Rocha** Brazilian Immigrant Center 139 Brighton Avenue - Suite 2 Allston, MA 02134 (617) 783-8001
Mr. Jean Marc Jean-Baptist Haitian American Public Health Initiatives 10 Fairway Street, Suite 202 - P.O. Box 386 Mattapan, MA 02126 (617) 298-8076	**Mr. Torli Krua** Liberian Community Association of Massachusetts 2377 Washingon Street Roxbury, MA 02119 (617) 445-5200
Mr. Van Christo Frosina Information Network/ An Albanian Immigrant and Cultural Resource 100 Boylston Street, Suite 930 Boston, MA 02116 (617) 482-2002	**Mr. Paulo Pinto** Massachusetts Alliance of Portuguese Speakers 1046 Cambridge Street Cambridge, MA 02139 (617) 628-6065
Mr. Sergey Bologov Russian Community Association of Mass.(*) 86 Lewis Street | 215-B Harvard Ave. Lynn, MA 01902 | Boston, MA 02134 (781) 581-0222 | (617) 731-7789	**Mr. Abdulkadir Hussein** Somali Development Center (*) 205 Green Street Jamaica Plain, MA 02130 (617) 522-0700
Mr. Blong Xiong Laotian American Organization of Greater Lowell 13 Ralph Street Lowell, MA 01851 (978) 452-3771	**Mr. Chong Moua Yang** New National Hmong-Lao Foundation 405 Main Street – P.O. Box 7591 Fitchburg, MA 01420 (978) 342-1892

(*)MAA ORIH/May 2000

The following publication lists agencies and the services they provide.

Multi-Cultural Populations Resource Directory
The Commonwealth of Massachusetts Department of Mental Health
Office of Multi-Cultural Affairs
25 Stanford Street
Boston, MA 02114
(617) 727-5500

The following series of pamphlets provide profiles of various newcomer communities, including helpful cultural background information.

Voices of the Community
Cross Cultural Health Care Program
Pacific Medical Center
1200 12th Avenue South, Seattle, WA, 98144
(206) 326-4161

1998 and 1999 PLINE (Primary Language is not English) Students

1998	Total Students Statewide	963,761	
1998	Total PLINE Students	122,891	
1998	Percentage PLINE Students	12.75%	
1999	Total Students Statewide	972,260	
1999	Total PLINE Students	128,555	
1999	Percentage PLINE Students	13.22%	

	1998	1998	1999	1999
LANGUAGE	NUMBER	% PLINE	NUMBER	% PLINE
SPANISH	62,861	51.2%	65,666	51.1%
PORTUGUESE	11,672	9.5%	12,424	9.7%
KHMER	7,706	6.3%	7,601	5.9%
CHINESE **	7,019	5.7%	7,212	5.6%
VIETNAMESE	5,712	4.6%	6,067	4.7%
HAITIAN CREOLE	4,403	3.9%	4,665	3.6%
CAPE VERDIAN	4,759	3.6%	4,401	3.4%
RUSSIAN	2,995	2.4%	3,144	2.4%
FRENCH	1,833	1.5%	1,963	1.5%
ARABIC	1,201	1.0%	1,394	1.1%
GREEK	1,027	.8%	1,047	.8%
KOREAN	872	.7%	1,019	.8%

** Includes Mandarin, Cantonese, and Taiwanese

Prepared by: Massachusetts Department of Public Health, Bureau of Family & Community Health, Office of Refugee & Immigrant Health

Data Source: Massachusetts Department of Education, Office of Technology/Data Collection

NORTH AMERICA

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EUROPE

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AFRICA

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ASIA


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LAOS
CAMBODIA
MALAYSIA
INDONESIA
PHILIPPINES
JAPAN
NORTH KOREA
SOUTH KOREA
BHUTAN
NEPAL
BANGLADESH
SRI LANKA
MALDIVES
BRUNEI
SINGAPORE
AUSTRALIA
Arctic Ocean
Indian Ocean
Arctic Circle
Equator
Tropic of Cancer
Scale 1:48,000,000
Azimuthal Equal-Area Projection
0 800 Kilometers
0 800 Miles
Boundary representation is not necessarily authoritative.
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